Annual National Report 2010

Pensions, Health and Long-term Care

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1 Executive Summary

Shortly before the deadline for submission of the present report, on 19 April 2010, the Croatian government published the (much awaited) comprehensive strategic guidelines for tackling the ongoing financial and economic crisis under the title "The Economic Recovery Programme".[1] Although the majority of activities envisaged in the programme are yet to be implemented and the framework for their operationalisation is still not established, this report includes current discussions and the possible impact of the reforms envisaged in the programme.

Fierce debate is instigated and loud criticism can be heard from the general, as well as professional public. The programme was drafted without participation of any social partners, and practically without any public debate. Generally speaking, the programme is regarded by the majority of people as a necessary evil, which will mostly affect the working, middle-to-lower-income population as well as the vulnerable, dependent categories of population. One thing should be emphasised: the programme was written by a group of economists, not politicians, but its implementation ultimately depends on the political will. Many of its goals could become diluted or its envisaged activities curbed in the process of its operationalisation at the level of responsible institutions.

The programme affects different segments of the social security system in Croatia. Its financial sustainability has become seriously compromised by the effects of the crisis. The underlying ideas behind the proposed reform activities in certain segments of the social security system are that of rationalisation, savings and reorganisation, in order to improve the efficiency of the system. Rationalisation in the health system will involve reduction in the number of hospitals and reorganisation of the emergency medical system (see chapter 2.2.1.3) and introduction of the system of concessions (see chapter 2.2.1.3). Their implementation will touch upon sensitive areas and entail some painful cutbacks. This will reflect in the pension system through the revision of early retirement schemes and a decrease of 'privileged' pensions (see chapters 2.1.4. and 2.1.2, respectively), as well as throughout the health system, notably through the reduction of the number of beneficiaries entitled to free additional health insurance (see chapters 2.2.3 and 2.2.4). However, these activities could only yield positive effects if activities for economic recovery, production growth, labour market activation and fostering of the investment climate are successful. Without reactivation of economy and labour market, cutbacks and savings affecting social protection rights could lead to further impoverishment.

The recorded statistics regarding the economic activities in Croatia in 2009 are alarming. As stated in the introduction of the Economic Recovery Programme, GDP is 5.8% lower than in 2008, industrial production is down by 9.2% as compared to 2008, a drop of more than 20% of goods export is recorded, unemployment has risen by more than 21.2% as compared to 2008, foreign debt has reached 98.5% of GDP at the end of 2009, which is HRK 4.3 billion higher than at the end of 2008. In March 2010, the registered unemployment rate reached its peak with 18.4%, and a further loss of 50,000 workplaces is expected in this current year. Given these figures, it is obvious that the sustainability of the social protection system will not be reached by savings only, but by promoting overall economic growth and creating a friendly and stimulative entrepreneurial environment. However, it seems that there is no real solution for these issues: the activities for achieving these goals are not presented nor

[1] The Programme is available on the webpage of the Government of the Republic of Croatia: http://www.vlada.hr/hr/naslovnica/novosti_i_najave/2010/travanj/predsjednica_vlade_predstavila_program_gospodarskog_oporavka

discussed as yet. The government requires solidarity and a sense of collective affiliation in the implementation of the programme, which also entails a shift in the dominant system of values within the society. However, it might be difficult to explain this to the majority of the population (i.e. the working population receiving an average net wage of HRK 5,157 (EUR 706), pensioners receiving an average net pension of HRK 2,165 (EUR 296.50),[2] unemployed, whose numbers are growing, and other vulnerable categories of the population) who will be most affected by the envisaged measures regarding the system of taxation and social protection savings. Social and regional inequalities persist; the gap between the extremely rich and the poor(er) (i.e. the majority of people) could become even deeper.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year

2.1 Pensions

2.1.1 Overview of the system's characteristics and reforms

The comprehensive reform of the pension system in Croatia started in 1998, with the introduction of the second and third pillar (see below), whose implementation was postponed until 2002. Pension insurance covers the risks of age, death and disability of the insured. The pension insurance system is regulated by the Pension Insurance Act,[3] the Act on Compulsory and Voluntary Pension Funds,[4] and the Act on Pension Insurance Companies and Pension Payments based on the Individual Capitalised Savings.[5]

It is based on three levels:

1. Compulsory pension insurance based on generation solidarity (pillar I)

2. Compulsory pension insurance based on individual savings (pillar II)

3. Voluntary pension insurance based on individual savings (pillar III).

All three pillars of pension insurance came in force on 1 January 2002.

All employed persons are placed into 3 categories within the new pension system:

a) Employees under the age of 40 have to be insured on two levels: within the system of compulsory pension insurance based on generational solidarity (pillar I), and within the system of compulsory pension insurance based on individual capitalised savings (pillar II).

b) Employees in the age group between 40 and 50 can choose to be insured only within the system of generational solidarity (pillar I), or they can choose to be insured in both pillar I and II (in this case they would have the same status as the category described under point a) - employees under the age of 40). The choice of the system is permanent and cannot be changed.

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2 All currency conversions in this report are based on an average exchange rate of EUR 1.00 = HRK 7.30, in accordance with the monthly accounting rate of the euro obtained on the InforEuro website: http://ec.europa.eu/budget/inforeuro/index.cfm?fuseaction=currency_historique&currency=86&Language=en.

3 Official Gazette of the Republic of Croatia, *Narodne novine* no.102/98, 127/00, 59/01, 109/01, 147/02, 30/04, 117/04, 92/05, 79/07 and 35/08.

4 Official Gazette of the Republic of Croatia, *Narodne novine* no. 49/99, 63/00, 103/03, 177/04, 71/07.

5 Official Gazette of the Republic of Croatia, *Narodne novine* no. 106/99, 63/00, 107/07.

c) Employees above the age of 50 can be insured only within the system of pillar I, which is within the compulsory pension insurance system based on generational solidarity, and cannot be insured within the system of compulsory individual savings (pillar II).

All employees, regardless of their age, can be included in the voluntary pension insurance system based on individual savings (pillar III).

2.1.1.1 Legal framework

The Act on Pension Insurance regulates the general pension insurance based on generational solidarity (pillar I). The Act on Compulsory and Voluntary Pension Funds regulates the issues of compulsory pension insurance based on individual savings (pillar II) and voluntary pension insurance based on savings (pillar III). The Pension Insurance Companies and Pension Payments Based on Individual Savings Act regulates the payment of pensions when an employee acquires the right to it. At that moment the funds from the account of a pension fund will be transferred to a pension insurance company which will make the payments of the pension to an insured person for life. The Decree on the Establishment of the Central Register of Insured Persons (REGOS)[6] regulates the establishment of REGOS, which has an important role in the functioning of the pension system. REGOS collects contributions of the members of compulsory pension funds and supervises the payment of contributions, keeps register of personal accounts of the members of compulsory pension funds, etc.

There are currently four registered compulsory pension insurance funds within the second pillar, six open voluntary pension insurance funds and 15 (12 of which are active) closed voluntary pension funds companies within the third pillar.[7]

The tables below indicate the total pension funds' membership, as well as the second pillar statistics.

Table 1: Pension fund's membership

Type of fund	2002	2003	2004	2005	2006	2007	2008	2009	01/2010	02/2010	03/2010
Compulsory pension funds (in thousands)	983	1,071	1,170	1,249	1,322	1,396	1,476	1,522	1,525	1,529	1,532
Open voluntary pension funds	1,345	8,773	30,022	51,121	75,161	103,923	127,738	146,410	147,778	149,561	151,803
Closed voluntary pension funds			1,112	5,336	10,663	11,943	17,285	17,733	17,727	17,708	17,700
Total (in thousands)	985	1,080	1,201	1,305	1,408	1,512	1,621	1,686	1,691	1,697	1,702

Source: HANFA - The Croatian Financial Services Supervisory Agency

6 Official Gazette of the Republic of Croatia, *Narodne novine* no. 101/99.

7 The Croatian Financial Services Supervisory Agency (HANFA), retrieved from: http://www.hanfa.hr/index.php?ID=0&LANG=HR&AKCIJA=10

Table 2: Number of new compulsory pension fund CPF members by method of joining in 2009

Months 2009	No. of new members		Of whom:	
	No. of members	Index 2009/2008	Applied in person	Allocated by REGOS
1	2 (4+5)	3	4	5
January	5,291	75.79	439	4,852
February	5,001	68.67	342	4,659
March	4,543	62.55	306	4,237
April	3,426	36.66	273	3,153
May	3,709	57.90	323	3,386
June	3,332	57.19	426	2,906
July	3,157	52.22	358	2,799
August	3,475	59.20	246	3,229
September	5,465	85.12	385	5,080
October	5,816	85.22	341	5,475
November	6,193	69.03	331	5,862
December	2,941	70.92	266	2,675
TOTAL	52,349	64.32	4,036	48,313

Source: REGOS - Central Register of Insured Persons, http://www.regos.hr/default.aspx?id=776

Table 3: Payments of 2nd pillar contributions in 2009 (HRK)

Months 2009	Monthly payments of 2nd pillar contributions in HRK	change from the previous month in %	change from the same month of 2008 in %	deviation from average monthly payments I–XII 2009 in %
1	2	3	4	5
January	379,674,150.27	-11.71	8.78	-1.74
February	365,748,296.43	-3.67	1.81	-5.34
March	392,756,239.38	7.38	10.50	1.65
April	384,122,153.44	-2.20	2.87	-0.59
May	375,504,536.55	-2.24	1.67	-2.82
June	390,966,942.92	4.12	1.45	1.18
July	400,517,802.20	2.44	0.72	3.65
August	386,562,396.06	-3.48	-0.47	0.04
September	377,529,425.80	-2.34	-3.05	-2.30
October	393,415,146.06	4.21	0.98	1.82
November	376,465,809.24	-4.31	-0.63	-2.57
December	413,519,016.91	9.84	-3.84	7.02
TOTAL	4,636,781,915.26	-	-	-

Source: REGOS - Central Register of Insured Persons, http://www.regos.hr/default.aspx?id=777

Under the Act on Compulsory and Voluntary Pension Funds, pension funds represent separate property without legal personality, established for collecting contributions from the members of the fund and their investment on the market in order to increase their value and pay pension benefits to the members of the fund.[8] Pension companies, established pursuant to the Pension Insurance Companies and Pension Payments Based on Individual Capitalised Savings Act, administer the pension funds. Each member of the compulsory pension fund has a personal account, which represents his personal property and may not be used before retirement. It is not subject to forced execution and is not part of the insolvency assets of the fund. The

[8] Article 35 (1) Act on Compulsory and Voluntary Pension Funds.

amount on the personal account may not be pledged nor transferred to any other person but the member.

As far as the voluntary pension funds are concerned (third pillar), they may be organised as open funds, where everyone can become a member, and closed funds, designed for specific groups, i.e. employees of a certain company, members of a trade union or an association of self-employed persons. The state offers incentives for members of voluntary pension funds (citizens of the Republic of Croatia, or any Member State of the EU, provided that the person has compulsory pension insurance in Croatia), which amount to 25% of the assets paid in the previous calendar year, up to a maximum of HRK 5,000 (approximately EUR 685). This incentive is funded from the state budget. Whether this incentive will 'survive' the planned tax reform is currently unclear. Another motivation for saving within the third pillar was the fact that it was recognised as tax relief within the personal income taxation (for savings up to HRK 1,000 per month). However, due to the planned abolishment of all tax reliefs in the system of personal income (as part of the fiscal reform introduced in the Government Economic Recovery Programme), the personal savings in the third pillar will not be recognised as a tax relief anymore, which might prove discouraging. Instead, the government intends to introduce incentives for employers who pay contributions for their employees in the third pillar, i.e. those payments will be recognised as tax expense.

Strict principles for investment of the property of the pension funds are prescribed under the Act on Compulsory and Voluntary Pension Funds. Investment should be made exclusively in favour of the members of the fund, in accordance with the principles of safety, rationality and caution, loyalty etc. The same act defines and enumerates the types of assets and securities in which the property of the pension fund may be invested, with or without the prescribed limitations. A list of prohibited investments is also prescribed. The Croatian Financial Services Supervisory Agency (HANFA) is authorised to extend the scope of admissible and prohibited investments, following the principles of safety, cost-effectiveness and marketability.

The prerequisites for realisation and the level of rights within the pension insurance were changed in the 1998 and subsequent pension reforms as follows:

• The retirement age was prolonged by five years (60 for women and 65 for men for old-age pension; early retirement: women 55, and men 60).[9]

• The possibility of achieving an old-age pension on the basis of the years of employment regardless of the actual age was abolished.

• Old-age pension could be realised in the transitional period, depending on age, which is the base for the early retirement pension, but the statutory period of employment is longer – 40 years of age for men, 35 for women.

• A new method for calculation of the pension increases the correlation of pensions with period and payments to pension insurance, which, in turn, favours contribution payment and late retirement.

• The lowest and the highest pension are established proportionate to the length of the pension period. This encourages longer employment and later retirement.

• The definition of disability has been reduced to general and professional incapacity for work, and working capacity is defined according to all types of work that are appropriate for the physical and psychological capabilities of the insured person.

[9] Gradual equalisation of retirement age for men and women by 2018 or 2019 is planned. See explanation under the sub-heading 2.1.4 *Critical assessment*.

• Pensions of military personnel and officials employed in the police and judicial system have been lowered by gradual expansion of employment years taken into consideration in calculating the pension from one to the ten most favourable years. Those were the privileged categories in the socialist system.

2.1.1.2 Financing

Mixed (public and private) financing is evident throughout the pillar structure. The contribution rates are prescribed under the Act on Contributions[10] and the Ordinance on Contributions.[11] The rate of contribution for persons insured within the first pillar (based on generational solidarity) is 20%. The rate of contribution for persons insured both within the first and the second pillar is split: 15% in the first pillar and 5% in the second pillar. The basis for calculation is the wage or other earnings (in case of employed persons) or income (in case of self-employed or other categories of insured persons). The contribution is paid up from the basis for calculation.

The share of total expenditures for pensions in GDP, according to the available data for 2007 is 11.15%. However, within this rate, 2.2% goes to payment of the so-called 'privileged pensions' to certain categories of pensioners, retired government officials and MPs being the most prominent category of pensioners, who receive significantly larger pensions than other categories of pensioners. This category also includes other pensioners who receive pension in accordance with special regulations, such as war veterans, police officers, judges etc. It is estimated that around 20% of the total number of pensioners receive privileged pensions.

2.1.1.3 Retirement age (prerequisites for eligibility for old-age pension)

A citizen is eligible for old-age pension from the age of 65 for men and 60 for women, provided that the person (excluding disability and other factors) has been employed for fifteen years. The same pension may be paid, regardless of a person's age, where a citizen is able to demonstrate a period of employment totalling 45 years for men and 40 years for women. An early pension may be attained by men upon reaching 60 years of age and by women upon reaching 55, provided that the citizen has performed 35 years of employment. It should be noted that the 15 years of employment requirement is satisfied when, during the preceding 24 months, unemployment benefits were requested for at least twelve months during that period.

2.1.1.4 Pension formula

The amount of pension payments is the product of personal points (PP), pension factor (PF) and the actual pension value (APV): pension = PP x PF x APV. The pension factor is determined in accordance with the type of pension (1.00 in case of old-age, early-retirement and disability pensions). The actual pension value is the determined amount of pension for one personal point. It is updated every six months at a rate which represents 50% of the rate of fluctuation of the average consumer price index and 50% of the rate of fluctuation of the average gross salary of all employees in the Republic of Croatia, in the preceding half-year period, compared to the six months before that (so-called "Swiss Formula", i.e. 50% of the price increase and 50% of the wage increase). Personal points are calculated in accordance with the prescribed formula and basically represent the worker's contribution to pension fund with their benefit. The Act on Special Tax on Salaries, Pensions and Other Income[12] has

[10] Official Gazette of the Republic of Croatia, *Narodne novine* no. 84/08, 152/08 and 94/09.
[11] Official Gazette of the Republic of Croatia, *Narodne novine* no. 2/09, 9/09 and 97/09.
[12] Official Gazette of the Republic of Croatia, *Narodne novine* no. 96/09.

suspended the adjustment of the pensions with effect from 1 July 2009 until the end of 2010. Despite the fact that the special tax itself has recently been abolished, prior to its originally prescribed duration (the 2% tax rate is to be abolished, effective from 1 July 2010 and the4% rate as from 1 November 2010), there is no proposal to amend the said act, in order to reactivate pension adjustment prior to the expiration of the prescribed standstill period.

Pursuant to legislative amendments which entered into force in January 2008, one of the factors for calculation of early-retirement pension benefit changed, resulting in more favourable terms for early retirement. The aim of this amendment, as stated in the explanation following the Draft of the Act on Amendments to the Act on Pension Insurance,[13] is to prevent pauperisation, and it encompasses all beneficiaries from 1 January 1999. Prior to this amendment, the percentage of reduction for each month of earlier retirement amounted to 0.34%, which resulted in an up to 20.4% decrease of the early retirement pension benefit in comparison to the minimum old-age retirement pension benefit. Monitoring of the implementation of this provision showed that, given the permanent character of this decrease, this percentage was too high. Therefore, the amendments adopted in July 2007, which entered into force in January 2008, prescribed a new reduction percentage of 0.15%, resulting in up to 9% of total reduction, in case the early retirement occurred five years before the fulfilment of conditions for old-age retirement. Another revision of the conditions for early retirement is planned, as part of the reform efforts within the new Economic Recovery Programme.

2.1.1.5 Disability pensions as a form of early retirement

There are two different categories of coverage: disability and accidents at work or professional diseases.

Disability coverage falls within the purview of pension insurance. Disability pension is granted in instances where a citizen's ability to work is diminished to such a degree that the statutory conditions are met, and where certain time limits, as defined by the law, are also met; this latter test, however, is not applied in instances of accidents at work or 'professional disease'.

Various forms of payment and services are envisaged for those meeting the eligibility criteria, including payment in kind in the form of treatment to facilitate rehabilitation.

Insurance coverage for accidents at work and 'professional disease' is provided under both the health insurance and pension insurance schemes, and, as a consequence, is administered by both the Health Insurance Institute and the Croatian Institute for Pension Insurance. Payouts for work accidents and work-related illnesses should compensate for an inability to work. They are granted without requiring a waiting period and are based upon the degree of the reduced ability to work and are more generous than for illness and disability due to other causes.

2.1.1.6 Taxation

Personal allowance is preferential, i.e. higher than that of other categories of tax payers. Given that approximately 85% of pension benefits are below the personal allowance, pensions are rarely taxed.

[13] Draft Act on Amendments to the Act on Pension Insurance, accessible on the official website of the Croatian Parliament: http://www.sabor.hr/Default.aspx?art=14829

2.1.2 Overview of debates / political discourse

The new Government Economic Recovery Programme[14] was published on 19 April 2010. The programme is presented in detail under the Heading 3: *Impact of the financial and economic crisis on social protection.* Suffice it to state here that the programme also addresses the issue of long-term sustainability of the social security system and identifies activities to be taken across the sector. Since it represents the most complete and comprehensive document for dealing with the impacts of the financial and economic crisis that the government has presented since the beginning of the recession, its different aspects will be commented on, where appropriate, in more detail in different sections of this report.

Financial (un)sustainability of the pension system is a matter of ongoing concerns and debates. There are several key areas in which these concerns are particularly reflected:

i. Sustainability of the second pillar (individual capitalised savings) and the issue of relatively lower pension for 'new' pensioners and early retirement

ii. Negative impacts of the financial and economic crisis:

   - Decreased employment rate;
   - Increased unemployment rate;
   - Non-payment of salaries (including pension, health and other social contributions) to an increased number of employees

iii. Issue of the so-called 'privileged' pensioners

iv. Modalities and timing for the introduction of the social pension

The Economic Recovery Programme addresses some of these concerns. The goal of the proposed reforms in the pension system is to ensure its long-term sustainability, under the circumstances of population ageing. The programme identifies six key activities aimed at achieving this goal, which should either be launched or show its first results in the short term, i.e. by the end of 2010:

1. Auditing the system of pensions obtained under special conditions and their decrease and preparation for gradual elimination of certain categories

2. Preparation to introduce the changes into the pension security system:

- Gradual adjustment of the legal age for obtaining early and regular retirement

- Modifications of rules for obtaining early retirement with financial sanctions for early retirement

- Gradual increase of contributions for the second pillar of pension insurance

- Acknowledgment of employers' contributions to the third (voluntary) pillar as a tax-recognised expense

- Decrease of management fees in the second pillar.

[14] See footnote 1.

i. Sustainability of the second pillar

Since the amount of pensions from the second pillar directly depends on the number of years of service,[15] the problem of lower pensions for the 'new' pensioners is likely to persist for some time in the future. The following activities represent the lynchpin of the reform:

- gradual adjustment of the legal age for early and regular retirement (gradual equalisation of retirement age for female and male employees);
- gradual increase of contributions for the second pillar;
- amendment of the rules regulating the right of early retirement with financial sanctions for early retirement;
- decrease of management fees in the second pillar.

The introduction of more stringent financial penalties for early retirement is unpopular and has instantly provoked criticism on the part of the representatives of the Croatian Pensioners' Party.[16] They claim that the early retirement in times of economic and financial crisis may be the only alternative to lay-offs as a result of workforce cutback. The majority of the working population who retire early may actually be forced to avail themselves of such option when faced with the prospect of losing their jobs.

ii. Negative impacts of the financial and economic crisis

The goal of the new Government Economic Recovery Programme is to reverse the negative economic trends by activating and providing the labour market with a new impulse. Namely, the second half of 2009 and the first quarter of 2010 has seen a significant increase of the registered unemployment rate: up to 18.4% in March 2010, which is a 19.2% increase as compared to the same month last year.[17] Unemployment grew in all counties during 2009.[18] One of the greatest risks for a sustainable pension system, as well as social protection in general, is a high unemployment and low employment rate. The already low dependency ratio has decreased even more, to 1:1.27 in February 2010 (see table 4 below). Another problem is that as many as 80,000 workers currently work without pay.

Activating the labour market is one of the priorities of the government programme. Its goals include ensuring labour force flexibility and employment security ("flexicurity"), as a common ("win-win") goal of social partners, and ensuring the relevant skills and knowledge for a dynamic economy and an open society.

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15 Latković, Mladen; Liker, Ivana, Analiza utjecaja parametara u kapitaliziranom sustavu mirovinskog osiguranja (Sensitivity Analysis of Accumulated Savings in a Defined-Contribution Pension System), *Financijska teorija i praksa 33 (4) str. 445-461 (2009).*

16 The Croatian Pensioners' Party is a curiosity in the Croatian political arena. Although its main area of interest lies in the improvement of the living conditions of the pensioners, its political influence is only marginal and its legitimation to represent all or the majority of pensioners is questionable – in the current term of the Croatian Parliament it has only 1 MP. The policy of the party consists of opportunistic formal (in the previous term of the Croatian Parliament) or *ad hoc* alliances with any governing party or coalition, in order to pursue its statutory goals.

17 Croatian Employment Service, Monthly Statistics Bulletin, year XXIII, no. 3/2010, retrieved from: http://www.hzz.hr/DocSlike/stat_bilten_03_2010.pdf

18 Analitički bilten HZZ (Analitical Bulletin CES), year XI, no. 4/2009, retrieved from: http://www.hzz.hr/DocSlike/analit.bil-4_2009.pdf

Proposed short-term activities[19] include:

1. Focusing the labour market policy on professional training, education, occupational retraining and adopting the key competencies, especially for the unemployed and inactive working-age population

2. Time limitation for receiving the full unemployment benefit, in order to motivate the unemployed to actively search for a job, and, after a certain period of time, paying 50% of the benefit, with an obligation to additional professional training or retraining

3. Introducing the system of volunteering, internship, training and probationary employment, for the young people to have their first working experience

4. Promotion of entrepreneurship should be partly decentralised and transferred from the Croatian Ministry of Economy, Labour and Entrepreneurship (MINGORP) to the regional development agencies

5. Ensuring the financial and institutional prerequisites:

- Directing the funds from contributions and from the European Social Fund towards the Croatian Employment Service
- Placing the funds with public procurement procedures on the NUTS II[20] level in accordance with the regional needs of the labour market, and in accordance with national and regional employment strategies
- Reshaping the Development Fund and employing people in the Fund for Education and Crisis Situations, whose financing comes from the contribution funds and co-financing from the social partners (equal parities) who use it and manage it without the state participating in it

6. Strengthening the capacities of the Croatian Employment Service (especially for counselling services and career development information) and linking its work with the activities of the Social Welfare Centres and the Agency for Vocational Education and Education of Adults.

Mid-term activities[21] for the activation of the labour market include:

1. Prolonging the duration of the right to financial assistance for the unemployed at risk of long-term unemployment

2. Strengthening the process of defining the Active Labour Market Policy and its decentralised implementation on the level of macro-regions, by strengthening the capacity of participants

3. Implementation of regular monitoring and evaluation of measures

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[19] Short-term activity has been defined as activities whose implementation must be effected or results achieved in the short term, i.e. by the end of 2008.

[20] The Nomenclature of Territorial Units for Statistics (NUTS) was established by Eurostat more than 30 years ago, in order to provide a single uniform breakdown of territorial units for the production of regional statistics for the European Union. In pursuance of its obligation under the Stabilisation and Association Agreement, the Republic of Croatia has also established NUTS regions. National classification of statistical regions in the Republic of Croatia is published in the Official Gazette of the Republic of Croatia, *Narodne novine* no. 35/07. NUTS II regions (established in accordance with the criterium of number of inhabitants) include 3 regions: North-West Croatia (6 counties), Adriatic Croatia (7 counties) and Middle and East (Panonian) Croatia (8 counties).

[21] Mid-term activity has been defined as that whose implementation must be taken or results achieved by the time of accession of the Republic of Croatia in the EU.

4. Gathering teams to define strategic projects for financing from the structural funds (access: sector, infrastructural, regional; themes-innovations, technological development, networking with the global knowledge nets, education).

Express reference to flexicurity as a common goal is just the beginning in the process of shifting the paradigm from job security to employability security in Croatia. However, the proposed activities are only partly compatible with the recommended EU flexicurity pathways: it seems as though the accent is more on flexibility i.e. through the cutting of rights (e.g. time limitation for receiving full employment benefit, promotion of volunteering as a way to gain access to first job experiences), with the security component lagging behind (no activities addressing e.g. adequate income support; lifelong learning strategies which take account of the Croatia-specific situation - inclusion of persons forced to retire early (war veterans, people who lost their jobs due to recession), but which are still able to actively participate in the labour market – for example, the possibilities to engage in a remunerated activity and still receive pension are very limited and, therefore, discouraging).
The speed of recovery of the private sector and the creation of new jobs will have a decisive impact. Otherwise, the unemployment rate risks further increase. Namely, the reduction of state expenses requires rationalisation of the system of public administration. The programme suggests a decrease of number of employees in public administration by 5%: conceptually, lay-offs should be avoided by retirement, outsourcing and decreased dynamics of new recruiting. However, the operationalisation of this idea will present a challenge, partly because the actual number of employees in the public sector and their structure is still not systematically recorded. The programme envisages the preparation of a registry of employees in the public sector by the end of March 2011, and a special office will have to be organised for that purpose alone. What will constitute a 'public sector' for the purposes of the registry (and rationalisation) is still not defined.

iii. Issue of the so-called 'privileged' pensioners

Out of 13 categories of the so-called 'privileged' pensioners, only three categories stand out: retired parliament representatives, retired members of the Croatian Academy of Arts and Sciences, as well as retired Croatian war veterans from the Homeland War. The amount of their pensions is between 2 to 5 times higher than the average pension of 'regular' pensioners. Around 15% of the overall number of pensioners receive privileged pensions, with HRK 7.2 billion or 20% of all pension expenditures in 2010 designated (in the state budget) for their payment (most of the said amount covers the pensions of the war veterans[22]). Apart from the obvious fact that the resulting financial burden is even more cumbersome in the light of the current economic and financial crisis, there is another important aspect which is a source of constant debates in Croatian society. With 50% of the regular pensioners[23] receiving less than HRK 2,000 (approximately EUR 273[24]) of monthly pension (the average pension in the group receiving between HRK 1,500.01 and 2,000 actually amounts to HRK 1,792.87 (EUR 245.60), which is below the poverty line[25]), the resulting social inequalities between different categories of pensioners are overwhelming. The proclaimed government position that all

[22] In 2009, the Act on Amendments to the Act on Rights of the Veterans from the Croatian Homeland War entered into force (Official Gazette of the Republic of Croatia *Narodne novine* no. 137/09). Its purpose was to put a stop to the further acknowledgement of the status of veterans from the Homeland War, volunteers from the Homeland War and members of the family of deceased veterans from the Homeland War and the right to a survivors's pension based on the death of a veteran from the Homeland War from disease, aggravation of disease or inception of disease during defence of the sovereignity of the Republic of Croatia after 31 December 1997.

[23] Calculation based on statistical reports of the Croatian Pension Institute for January 2010.

[24] See footnote 2.

[25] World Bank data and statistics.

categories of society should equally bear the burden of the crisis, thus, falls short of its underlying idea of solidarity.

The proposed government activity within the Economic Recovery Programme includes the revision of all pensions acquired under privileged terms and their reduction, as well as the preparation for gradual abolishment of certain categories of privileged pensions. This is the only proposed activity that met with general public approval, for all the previously stated reasons. Some estimates show that a linear reduction of 10% of all privileged pensions should lead to a saving of HRK 720 million. However, the modalities for the implementation of this activity are yet to be proposed and analysed.

iv. Modalities and timing for introduction of the social pension

The legal framework for the introduction of the social pension or 'support for the elderly' will be included in the new draft of the Social Welfare Act, whose adoption is expected by the end of 2010. This means that social pension will be financed as part of the system of social welfare. However, the modalities of its determination are still not clear and detailed further assessments are needed. Some estimates show that around 40,000 elderly could be entitled to such pension, which would entail expenditures of between HRK 150 and 200 million annually.

2.1.3 Impact assessment

2.1.3.1 Financial sustainability of the pension system

Population ageing, a high unemployment rate exacerbated by the effects of the recession, a low replacement rate and a high dependency ratio are still the sore spots of the Croatian pension system. The registered unemployment rate in 2009 actually surpassed the estimates[26] and continues to grow. This means that throughout 2009, the dependency ratio continued to drop. According to available data (see table 4 below), the dependency ratio in February 2010 was 1:1.27, compared to 1:1.37 in the same month of last year. These figures reflect the negative trends in the labour market, which are among the biggest threats to system sustainability. Apart from the registered statistics, a growing number of workers work without pay, which means that employers are not able to pay the contributions to the pension funds either. According to some pessimistic assumptions by representatives of trade unions, up to 80,000 employees[27] currently work or have worked for some time without pay.[28]

The wage cut for public servants during 2009 as well as the high unemployment rate have also contributed to a decrease of contribution payments to compulsory pension funds (the amount of charged contributions in January 2010 was 16% lower than in the same month of last year). The difference between the amount of the contributions collected and the expenditures for payment of pensions in 2010 could rise up to HRK 17 or 18 billion.[29] This could represent HRK 2 to 3 billion more than planned in this year's budget. Namely, planned revenue from the collection of contributions for pensions is HRK 19.86 billion, while planned expenditure for payment of pensions is HRK 35.21 billion. Should these estimates prove true, the shortage of the pension system will be approximately 28% higher than in the previous year, and up to 70% higher than in 2002.

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[26] See Croatia ANR 2009, p. 11.

[27] Average number of employed persons in 2009 was 1,498,784. Analitički bilten HZZ (Analitical Bulletin CES), year XI, no. 4/2009, retrieved from: http://www.hzz.hr/DocSlike/analit.bil-4_2009.pdf

[28] There are no official statistics available, but the unions estimate that as many as 30,000 to 80,000 employees work without pay, regardless of the time when those workers received their last wage.

[29] As stated by the Prime Minister Kosor and reported in the daily newspaper Novi list, 30 April 2010.

However, compulsory pension funds have, nevertheless, managed to end the year with a positive trend, with a 8.7% yield. The calculations show that net assets of the compulsory pension funds are increased by approximately HRK 3 billion since the start of their operations.

2.1.3.2 Development of replacement rates

Minor fluctuations in the replacement rates are evident throughout 2009 and the first three months of 2010 (see table 4 below). One of the first measures presented by the government for the implementation of the Economic Recovery Programme is the abolishment of the special tax on salaries, pension and other income (introduced in July 2009 for all income above HRK 3,000). The Croatian Parliament already voted on the abolishment of the first differential rate of 2%, paid on net monthly income between HRK 3,000 and 6,000, which should enter into force on 1 July 1 2010. The abolishment of the differential tax rate of 4% on net monthly income above HRK 6,000 is in the parliamentary procedure of legislative amendments, and is expected to be adopted and enter into force as of 1 November 2010. Approximately 290,000 pensioners were included in the system of payment of special tax, while around 870,000 pensioners were outside the scope of this measure.[30] With the expected mild increase of the net average salary, minor adjustments of the net replacement rates are expected as of the second half of 2010.

2.1.3.3 Labour market participation of the elderly

Labour market participation of the elderly should be observed in light of the overall drop in economic activities, meaning that the unemployment rate grew in 2009 across all age cohorts. The average registered unemployment rate was 14.9% in 2009[31] (the overall drop in economic activities and a negative GDP rate of -5.8%[32] in the same period is observed). The registered unemployment rate continued the negative trend, increasing towards the end of 2009 and peaking at 18.4% in March 2010.[33] The share of unemployed among the 60+ age group grew by 2.9% in March 2010 as compared to the same period last year.[34] Given that mostly young workers are affected by the negative trends, the current Government Economic Recovery Programme does not specifically address the participation of the elderly in the labour market. Instead, it is focused on measures for activating the labour market and bringing more people into work, such as professional retraining and promotion of flexibility in the labour market.

On 21 May 2009, the Croatian government adopted a decision accepting the National Plan for Stimulation of Employment in 2009 and 2010,[35] with measures for implementation in accordance with the priorities of the employment policy set in the revised Lisbon Agenda on employment growth. One of the identified key priorities is the increase of the level of employment and participation of older persons in the labour market, and the Croatian Pension Insurance Institute was assigned with the task of devising a policy for stimulation of active ageing and ensuring adequate incentives for employees to remain working, including de-

30 Prijedlog zakona o izmjeni Zakona o posebnom porezu na plaće, mirovine i druge primitke, s konačnim prijedlogom zakona (Draft Act on Amendments of the Act on Special Tax on Salaries, Pensions and Other Income, with final proposal of the act), available on the official website of the Croatian Parliament: http://www.sabor.hr/Default.aspx?art=32875

31 The registered unemployment rate is calculated as the ratio of unemployed persons to the total active population (labour force).

32 Croatian Bureau of Statistics, monthly preliminary report for March 2010; Estimates of the Croatian Institute of Economics show a decline of 5.9%.

33 Croatian Bureau of Statistics, monthly preliminary report for March 2010.

34 Croatian Employment Service, Monthly Statistics Bulletin 3, year XXIII, 2010.

35 Retrieved from: http://www.mirovinsko.hr/default.asp?ID=2151

motivating early retirement. The envisaged activity for implementation is to inform the public (business community and pensioners) about the possibilities to work while in retirement. No statistics or data are available regarding the implementation of this activity, whose purpose is not to offer incentives to create jobs for elderly, but to inform about such possibility.

2.1.3.4 Gender impact of the pension reform

The completion of equalisation of the retirement age between men and women is not expected before 2018. Positive effects of this measure are to be expected, given that there are no differences in the calculation of benefits and pensions for men and women. These effects should be noticeable in the mid term, i.e. the expected net replacement rate for women should reach that of men.

Another measure, which is part of the social welfare reform, should serve to overcome the gender gap when it comes to elderly without any income. Namely, women account for 95% out of the 12.4% of the elderly population (65+) without any income.[36] The introduction of the legal framework for the so-called social pension for persons without any income, which should replace other monetary entitlements under the current social assistance system, is expected by the end of 2010 (within the new Social Welfare Act).

Table 4: Statistical data

2009 (month)	No. of contributors	No. of pensioners*	Dependency ratio**	Average pension (HRK)	Net replacement rate ***	Estimate of necessary funds for payment of pensions (HRK)
Feb 2010	1,499,465	1,181,932	1:1.27	2,164.62	41.17%	2,950,850,000
Jan 2010	1,507,067	1,178,449	1:1.28	2,166.44	40.40%	2,925,300,000
Dec	1,530,233	1,178,814	1:1.30	2,169.32	40.28%	2,939,300,000
Nov	1,548,008	1,172,500	1:1.32	2,170.29	41.11%	2,933,500,000
Oct	1,556,919	1,171,173	1:1.33	2,170.57	41.45%	2,931,000,000
Sept	1,575,219	1,167,717	1:1.35	2,172.48	41.25%	2,921,000,000
Aug	1,592,045	1,164,216	1:1.37	2,172.68	40.93%	2,958,350,000
Jul	1,598,093	1,162,531	1:1.37	2,148.00	40.00%	2,870,320,000
Jun	1,596,346	1,159,881	1:1.38	2,166,01	40.67%	2,880,000,000
May	1,587,006	1,158,665	1:1.37	2,167.03	40.43%	2,880,000,000
Apr	1,579,484	1,155,307	1:1.37	2,169.64	41.43%	2,868,000,000
Mar	1,578,709	1,154,798	1:1.37	2,165.68	41.41%	3,040,000,000
Feb	1,581,882	1,152,947	1:1.37	2,125.22	40.05%	2,805,000,000
Jan	1,587,365	1,150,093	1:1.38	2,126.73	39.31%	2,807,000,000

** including old-age, disability and family pensions*
*** ratio between contributors and pensioners*
**** net average pension expressed as a percentage of the net average wage*
Source: HZMO (Croatian Institute for Pension Insurance)

2.1.4 Critical assessment

As the cross-comparison with the pension OMC objectives hereunder will indicate, the proposed reform activities are generally targeting in the right direction, but a number of parameters, most notably the revival of the economic sector, will influence the pace and level

[36] Nestić, D.; Rašić Bakarić, I., From work to retirement: Pension System Incentives to Continued Labour Market Participation in Croatia, in: Vehovec, M., *New Perspectives on a Longer Working Life in Croatia and Slovenia*, The Institute of Economics, Zagreb and Friedrich-Ebert-Stiftung, 2008, 90.

of achievement. Increasing the rate of contribution in the second pillar only partially deals with the issue of its financial sustainability. Namely, the amount of pension acquired on the basis of first and second pillars is highly sensitive on the duration of insurance, i.e. the years of service. This could explain the lower pension of those insurees from both pillars who have saved within the second pillar for a short period before entering early retirement.[37] The three main parameters determine the calculation of capitalised assets in the individualised capitalised system of pension insurance: duration of saving, fund yield and rate of gross wage growth. An increase of the rate of contribution will, if observed in the shorter term, have the effect of elevating the importance of the rate of gross wage growth in comparison with the importance of the yield of the fund.[38]

Therefore, the reform efforts should not be concentrated only on the rate of contribution, and neglect to properly address the true challenge: low employment rate and unsustainable dependency ratio. The pension system reform will not yield desired results, unless these negative trends are overturned. Viewed from this perspective, the objective of *balancing contributions and benefits in an appropriate and socially fair manner* seems one-sided, i.e. inclined towards the increase of contributions, aimed at salvaging the financial sustainability, without that increase reflecting positively on benefits.

There are virtually no changes in comparison to the previous annual report regarding the objective of *adequate level of retirement incomes and access to pensions*: the average pension in 2009 was approximately HRK 2,160 (EUR 295) per month, which is just above the poverty line of HRK 1,845.42 per month.[39] According to the data from January 2010, more than half of the total of 1,088,940 pension beneficiaries (old-age, disability and family/survivor's pensions), i.e. 549,410 pensioners, received pensions of less than HRK 2,000 (EUR 273). It is estimated that around 40,000 persons could become eligible for the social pension, depending on the parameters applied. The actual number of elderly without sufficient means of living and without pensions could be higher. Their status is extremely vulnerable and is currently covered by various social assistance entitlements.

Some projections show that the gradual equalisation of the retirement age for women and men up to the age of 65 years should follow a pattern of six month prolongation each year, so that the final equalisation should take place in 2018. This is actually not a genuine novelty, since the Croatian Constitutional Court passed a decision in 2007 in which the current difference in retirement age for men and women was judged to be contrary to the constitutional guarantee of gender equality, and the obligation of gradual equalisation of the retirement age for women and men by 2019, at the latest, was established.

The development of other accompanying measures in the pension reform, such as the revision of rules for early retirement, including financial sanctions for early retirement, although they might seem socially insensitive, due to the circumstances, is also a necessity. These activities, if implemented appropriately, could work towards achieving the OMC objective of *more people at work and working longer*. In 2009, this objective was far from being properly addressed and, unfortunately, the prospects for it are not favourable for 2010 either. The practical implementation of the proposed structural reforms in the labour market and other sectors by the end of 2010 is crucial and will show if this objective is to become more realistic in the years to come.

The *Promotion of the affordability and the security of funded and private schemes*, as one of the pension OMC objectives, is more likely to be slowed down in the next period. Namely,

[37] Latković. M.; Liker, I., op.cit., 455.
[38] Ibid., 459.
[39] World Bank data and statistics.

abolishment of all tax reliefs within the system of personal income is announced as part of the tax reform within the Economic Recovery Programme. This means that personal savings within the third (voluntary) pension system pillar, up to HRK 1,000 per month, are no longer refundable as tax relief, which could negatively affect the motivation of the citizens to save within this pillar. The government has, however, proposed an alternative incentive for saving in the third pillar through acknowledging this expense of the *employer* as a tax-recognised expense. So far, no discussions have addressed this issue and there are no available studies of the impact of such measure. At the end of March 2010, 151,803 insurees had accounts in 6 open voluntary pension funds, with total assets slightly below HRK 1.3 billion.[40] Meanwhile, there are 17,700 members in 15 (12 active) closed voluntary pension funds, with total assets of HRK 243.55 million in the same period.[41]

Professionals in the field of personal and life insurance, which could also be viewed as a means of saving for the old age, are also expressing their concerns about the abolishment of tax reliefs. They are worried that this fact might cause a 'chain reaction': demand for financial services aimed at saving for the old age could diminish, which means a lower number of new insurance policies. This, in turn, affects the assets of the insurers, who will no longer be able to purchase government bonds, which, in turns means fewer assets for the state to service its debts.[42]

2.2 Health

2.2.1 Overview of the system

2.2.1.1 Health care reform of the 1990s

It is impossible to provide an overview of the current system without a historical reference to the health care reform. The transition from collective/state economy to private/market oriented economy has had a profound influence on the health care system as well. On the other hand, the evaluation of legal and organisational changes introduced in 1993 cannot be separated from the description of the system's functioning until the end of the last decade of the20th century.

The prevailing opinion is that Croatia entered the 1990s with a dysfunctional, inefficiently organised and expensive health care system, which had to be completely restructured.[43] The goals of transition in the economic and political aspect were clear (market and democracy) – although the paths to it were not – but this may not be said for the transformation in the field of social policies.[44] The need to adjust the health care system to the new social and economic circumstances was entirely undisputable, but the first reforms taught us that, if taken "lightly" (many advantages of the reform were explained merely through a detachment from the old system), such an approach may lead to many unwanted consequences. After 1993, the health care system had started to show first signs of a permanent crisis. However, the World Bank

40 HANFA; http://www.hanfa.hr/index.php?ID=0&LANG=HR&AKCIJA=10

41 Ibid.

42 As reported in the daily newspaper Novi List, 22 April 2010.

43 European Observatory on Health Care Systems, Health care systems in transition. Croatia, 1999, retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0018/75150/E68394.pdf

44 Zrinščak, S., Zdravstvena politika Hrvatske. U vrtlogu reformi i suvremenih društvenih izazova (Croatian Health Care Policy. In the Whirl of Reforms and Contemporary Challenges in the Society), *Revija za socijalnu politiku, (Journal of Social Policy)*, volume 14, no. 2, 2007, pp. 193-200, 199.

spoke highly of the results of the reforms, or rather its financial impact, calling them impressive, but, nevertheless, predicted skyrocketing expenses in the future.[45]

The framework for reforms was also shaped by the factors of economic and social consequences of system transformation and the war, which imposed the maintenance of a basic health care security and the issue of health care expenses as a priority. In the case of Croatia, this is visible in the strong, long-term and direct impact of global agencies and the World Bank, in particular, in the Croatian health care system reforms.[46]

The main characteristics of the health care reform in 1993 were centralisation and privatisation. Being the first extensive health care reform, the 1993 reform was implemented in the subsequent few years and tried to solve the problems of the past system (too many expenses and an inherited debt, inefficient decentralisation), new social problems (the health care crisis, caused by economic difficulties and the war), and new social circumstances (the freedom of patients to decide, the right to private practice).[47]

The basic division was preserved, and it included primary (medical centres, institutions for emergency medical assistance, and institutions for secondary care at home, pharmacies), secondary (policlinics, hospitals, and sanatoriums), and tertiary medical care (state medical institutes, clinical institutions). It was prescribed that everyone is obliged to take care of their own health and to freely choose a doctor, which certainly represented a legal novelty, even

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45 Svjetska banka (1997) (World Bank, 1997), Financiranje javnog sektora, reforma zdravstva i mirovinska reforma u Hrvatskoj (Financing of public sector, health care and pension system reform in Croatia), *Revija za socijalnu politiku, (Journal of Social Policy)* volume 4, no. 3, pp. 265-285; World Bank, 1999, Croatia. Health Policy Note, Document no.19505-HR. This evaluation is based on a centralised control of the courses of financing, the mechanisms introduced to control the expenses, and the set foundations of the privatisation of health care. In 1993 and 1994, the total costs of the health care system were diminished and the deficit in the Croatian Institute for Medical Insurance (HZZO) was reduced from 2.8% of GDP in 1992 to 0.2% in 1994. But this was not accomplished by a significant reorganisation of the health care system, but rather through financial measures, which lost their effectiveness very soon, such as the increase of the contribution rates and the introduction of the system of limited expenses. The diminution of expenses in health care was also affected by a decision in 1994 to no longer report the amortisation expenses in accounting records, which led, in the long run, to a very negative consequence for the investment maintenance and the renewal of capital equipment. That is the reason why the World Bank evaluated this reform as impressive and, at the same time, pointed to skyrocketing expenses in the second half of the 1990s and a series of other problems of the system's functioning. For example, the explicit goal of the 1993 reform was the strengthening of the role of primary medical care and the solving of issues on the primary level, without the often unnecessary reference to specialists and hospitals. But in 1995, primary medical care used only 14.6% of the total health care expenditure and, in the same period, the hospital expenses rose by 3%.

46 The impact of the World Bank on the Croatian health care system, as well as the social system in general, is evident throughout the entire process of reforms. The policy approach is shaped in accordance with the World Bank surveys and proposals. For example, the first project agreed between the World Bank and the government of the Republic of Croatia, which started in 1995 and ended in 1999, amounted to USD 54 million. It was created to support the 1993 reform through the introduction of an information system and the supply of medical equipment. The next project, which came into force in March 2000, marked a new period in the ambitious health care reform. Its aim was fostering privatisation of the primary level health care; unfortunately, the results of the pilot project initiated under this project, according to Zrinšćak, were never systematically evaluated nor used as a basis for development of further strategies. In June 2000, the Ministry of Health and Social Welfare adopted the document entitled "Strategy and Plan of the Reform of the Health Care and Health Insurance in the Republic of Croatia". The document then served as a basis for preparation of the strategy of the development of health care, which was part of a larger government project at that time under the title "Croatia in the 21st century" (Office for Strategy, 2002). The overall reform of the health care system included a series of changes in the health care system management, the effectiveness and quality improvement and the strengthening of the preventive and primary medical care. Among others, it was planned to define the basic package of medical services, improve the payment system in order to use services more rationally, define a network of medical capacities, introduce more rational medical procedures by defining clinical guidelines, rationalise drug consumption, and similar.

47 Zrinšćak, S., op. cit., 199.

though, at that time, there was no Act on the Protection of Patients Rights and, given the very low level of awareness, it was more of a declaratory, rather than a realistic possibility.

The process of privatisation was the issue which caused most concern from the outset.[48] Namely, the law differentiated ownership between the central state and the counties:

- the state owned clinics as independent institutions, clinical hospitals, clinical hospital centres and state medical institutes,
- the counties and the City of Zagreb owned medical centres, home care medical institutions, policlinics, general hospitals, special hospitals, pharmacies, sanatoriums, emergency medical assistance institutions and institutes for public health and transfusion medicine.

It was prescribed that all medical institutions, owned by counties, may be in private or mixed ownership, except for medical centres, emergency medical assistance institutions and institutes for public health and transfusion medicine. A new form of ownership over medical institutions was best reflected in the managing bodies, i.e. managing boards, where the majority was held by the owner (either the state or the county).

The regulation of financing the health care system followed a similar logic, but it showed a lot more centralisation. As the system was still basically founded on the obligatory medical care insurance and the payment of contributions (along with additional income from the state budget and participation of the insured), the basic institution became the newly established Croatian Institute for Medical Insurance (HZZO).

Based on insurance, the insured are entitled to medical care (primary, specialist – consulting and clinical) and to the following financial compensations:

- remuneration during sick leave,
- compensation for travel expenses in relation to using medical care,
- aid for buying equipment for a newborn child,
- compensation for funeral expenses.

The specific aspect of privatisation consisted of the introduction of participation for certain services and the possibility for some doctors to provide certain medical services privately, in the premises of state medical institutions, after their mandatory working hours.

In this way, the general and medical care accessible to all in principle, was explicitly connected to the possibilities of direct payment, and the possibility of private work in public institutions inaugurated a (non)regulated public-private mix, which did not prove to be a good solution anywhere and which makes a series of abuses of the right to equal access to medical care possible and causes real difficulties in the access to medical care (more on this issue can be found further below).[49] It is interesting that the World Health Organization did not recommend this solution and that it was the pressure of medical workers, which lead to it.[50]

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48 "The World Health Organization advised the legislator not to rush with the privatisation, because of negative experiences of countries which attempted to do so (Hungary) and also, because of the significant factor that people were not used to private ownership in the health care segment." See: Hebrang, A., Njavro, Đ., Mrkonjić, I., Komentar Zakona o zdravstvenoj zaštiti i Zakona o zdravstvenom osiguranju (Commentary of the Health Protection Act and the Health Insurance Act), Zagreb, Privredni biro, 1993, 17, 18. It must also be said that the level of centralisation was lower than, for instance, in the educational or social care system, at that time.

49 Zrinšćak, S., op. cit., 201.

50 "The recommended frames of this world organisation imposed a rule of non-mixing of private and state ownership in the same institution, which the legislator observed in the first version of the act, but later partly gave in under the pressure of medical workers." Hebrang, A., Njavro, Đ., Mrkonjić, I., op. cit., 18.

2.2.1.2 Legal framework

Generally speaking, the Croatian social security system is based on the principles of universality, continuity and accessibility.[51]

The operation of the principle of universality ensures that social insurance protection is, in principle, provided for the entire population of the Republic of Croatia (Art. 58 of the Constitution). The principle of continuity is reflected by the fact that, for example, medical insurance is provided to citizens of all ages throughout their lives, without any interruptions.

The principle of accessibility ensures that there is an attempt to provide all Croatian citizens with medical care, regardless of the remoteness of the location and the costs involved in providing such care.[52]

On 1 January 2009, the new Health Protection Act entered into force.[53] It replaced the previous Health Protection Act and its changes and amendments.[54]

Health care is defined as a system of social, group and individual measures, services and activities aimed at preserving and improving health, prevention of disease, early discovery of illness and timely treatment and medical care and rehabilitation. It is organised on three basic levels:

- primary,
- secondary,
- tertiary, and
- on the level of medical institutes.

The payment of medical care in the primary medical care is performed through so-called '*glavarina*' (payment per capita or capitation), and, in 2004, a payment mechanism was introduced according to service, at first for preventive programmes and then also for curative care. Since 2005, a payment mechanism according to therapeutic procedure (or the so-called diagnostic groups system) has been in place. Clinical medical institutions are financed through monthly budgets – limits which the institutions justify by the invoices made for the activities performed. Here, the clinical medical care is also, along with defining the total budget, paid by the payment mechanisms according to service and payments in accordance with therapeutic procedures. Capital investments are financed by the means of the HZZO, ministries, and decentralised means of the regional and local self-government and through donations.

The primary level of health care includes: observing the health condition of the population and the suggestion of measures to protect and improve the health of the population, the prevention and discovery of illness as well as rehabilitation of patients, the specific preventive protection of children and juveniles, the medical protection of women, the preventive medical protection of groups at risk, according to programmes of preventive health protection, counselling, medical education and promotion of health in order to preserve and improve it, hygiene-epidemiologic protection, prevention, discovery and treatment of teeth and mouth illnesses with rehabilitation, health rehabilitation of children and juveniles with disorders in physical and mental development, home visits, medical care and home treatment,

[51] Bodiroga-Vukobrat, N., in: Tomandl, T., Mazal, W. (Hrsg.): Soziale Sicherheit in Mitteleuropa, Wien, Orac, 2000, 41-42.

[52] Bodiroga-Vukobrat, N., 'Social security system' in: WILIAMS, S., Modern Legal Systems Cyclopaedia, Hein, 2005, 149-159.

[53] Official Gazette of the Republic of Croatia, *Narodne novine* no. 150/08, 155/09.

[54] Official Gazette of the Republic of Croatia, *Narodne novine* no. 121/2003, 48/2005, 85/2006, 117/08.

occupational medicine, emergency medical care, palliative care and protection of mental health. Institutions on the primary level are medical centres, institutions for emergency medical care, institutions for medical care, pharmaceutical institutions and institutions for palliative care. All these institutions are owned by the counties, although there exist a number of doctors in the medical centres who, due to the aforementioned process of privatisation, have their practices in lease. The secondary level health care system comprises specialist and hospital activity. The institutions at this level include policlinics, hospitals and sanatoriums, again owned by the counties.

The institutions on the tertiary level (clinical institutions) are owned by the state and provide the most sophisticated form of medical care in specialist and hospital activity as well as perform scientific research and education.

The activity of medical institutes is part of the health care activity, which is performed in the primary, secondary and tertiary level of medical activity. On the level of state medical institutes, it comprises public health activities, labour medicine activities, the activity of transfusion medicine and activities of mental health care, and on the level of medical institutes of regional self-administration units, it comprises the public health activities.

The new Obligatory Medical Insurance Act entered into force on 1 January 2009,[55] replacing the previous act[56] under the same title from 2006. Medical insurance is defined as obligatory on the one part, carried out by the Croatian Medical Insurance Institute, and voluntary on the other part, which is defined by particular regulations. The act defines single categories of persons who are covered by the medical insurance, e.g. employed persons, or other persons such as members of their families, people undergoing education, people registered with the employment institutes, and so on.

In fact, almost the entire population is covered by obligatory medical insurance, which is visible from the data, which shows that about 97% of the population are insured, whereas non-insurance is mostly a consequence of disregarding deadlines for registration with the HZZO, and often applies to persons working temporarily abroad, who have not regulated their status in Croatia.

The rights from medical insurance cover:

- the right to medical care,
- the right to financial compensation.

The rights to medical care include:

- primary medical care,
- hospital medical care,
- the right to obtain drugs as established in the basic and additional list of drugs of the institute,
- the right to dental-prosthetic care and dental-prosthetic implants,
- the right to orthopaedic and other apparatuses,
- the right to medical care abroad.

The Obligatory Medical Insurance Act defines which parts of medical care are fully covered for the insured, and which are partly covered, by 85%, 75%, 70% and 50% of the price. The

[55] Official Gazette of the Republic of Croatia, *Narodne novine* no. 150/08, 94/09 and 153/09.

[56] Official Gazette of the Republic of Croatia, *Narodne novine* no. 85/06, 105/06, 118/06, 77/07, 111/07 and 35/08.

latter comprises, for example, dental medical care regarding mobile and fixed prosthetics of adults. The obligatory insurance fully covers the cost of drugs on the basic list, while the additional list includes the amount to be contributed for single drugs.

Prior to the newest reform (see explanation under the sub-heading 2.2.4 *Critical assessment*) the following categories of population were exonerated from co-payments for medical care:

- children up to 18 years of age,
- disabled persons and other persons who have been entitled to be assisted by another person in performing most or all vital functions according to special regulations,
- persons with at least 80% physical disability pursuant to pension insurance regulation and the Act on Rights of Croatian Veterans from the Homeland War and Members of their Families, or other special regulations, as well as physically disabled persons,
- voluntary blood donors with over 35 donations (men), and 25 donation (women),
- persons whose income per family member in one calendar year does not exceed a certain amount (or if the total monthly amount per family member does not exceed 45.59% of the state budget base, for single pensioners 58.31%).

When the Obligatory Medical Insurance Act was in the process of adoption, the last category was the one to raise most public attention because the issue was how much of a negative impact the provisions on co-financing will have on the accessibility of medical care for the poorer. It is important to mention here that we talk about total income, even though it remains unclear, in which way these total incomes are established. Around 360,000 beneficiaries are now set to lose the right to free additional health insurance, financed by the state (exoneration from co-payment).

The right to financial compensation covers:

- remuneration for temporary impediment or inability to work due to use of medical care (sick leave) or financial compensation due to impossibility to perform activities which generate other income,
- compensation of transport costs in relation to using medical care from obligatory medical insurance.

The Voluntary Medical Insurance Act[57] defines voluntary medical insurance as:

- supplementary,
- additional,
- private.

Supplementary medical insurance covers part of the expenses up to the full price of medical care from obligatory medical insurance. Additional medical insurance covers a higher standard of medical care, in relation to the standard foreseen by the obligatory medical insurance, and a larger scale of rights when compared to obligatory medical insurance. The private medical insurance covers medical care for persons in Croatia who do not have obligatory medical insurance according to the Obligatory Medical Insurance Act, and foreigners.

In this context it is necessary to also mention the Patients' Rights Protection Act[58] which, for the first time, regulates the rights of patients. It is an important step in the Croatian health care

[57] Official Gazette of the Republic of Croatia, *Narodne novine* no. 85/2006, 150/2008.

system, in spite of much criticism about the declarative nature or inapplicability of the said act – the way from legal formulations to actual fulfilment and enforcement of the rights in real life will certainly be a long one.

The ‚Latest' Reforms

Pivotal points of the reform activities are concentrated on the system of concessions in primary health care, rationalisation of hospital networks and rationalisation of emergency medical services.

System of concessions in primary health care

A system of concessions for the provision of public health care services is introduced as part of the health care reform. The State Secretary for Health Care, Dr. Dražen Jurković, has explained that the basic issues in reforming the primary health care system include the rational use of primary health care services (Primary Health Care Service – PZZ – as the guardian of the system), regulating the relations between the contractor and the health care provider (lease), the status of contractors, the imbalance of services in the primary and secondary health care, which is 1:1, instead of 3:1, the PZZ payment model (the capitation is not stimulative and does not pay for the work of PZZ physicians, hence all the patients are directed to hospitals), active engagement of the local community (decentralisation) in planning and implementing the health care, as well the issue of health centres' status and their position in the PZZ system (the principle of a double griddle), and the emergency medical service (HMP) reform.

Since the lease, which is a specific Croatian solution and does not exist anywhere else in the world, is related to the space and not to the status, it does not resolve the physicians' status. The relations between the service provider and the service financier have been neither resolved nor regulated. Therefore, as Mr. Jurković points out, the ministry sees the concession as the only applicable model in Croatia that would regulate these issues.[59]

In accordance with the new Health Protection Act, the PZZ may be carried out as a public service (health care institutions), as a private practice that is carried out on the basis of public authorisation (concession), and as a private practice on the market. Thus, the PZZ physicians have three options on how to perform their services. The concession is not obligatory, so the physicians who do not want to enter the concession or who do not obtain it have an option of going back to the health centre or opening their private practice.

The legal basis for normative regulation of concession in the PZZ in Croatia is the Act on Concessions,[60] as well as the Health Protection Act. The concession enables the holder to obtain the right to perform their services and it is issued on the basis of a public bid that ensures transparency, equal treatment and non-discrimination.

The concession in the PZZ regulates the provision of health care services by the private health care employees and health care institutions in the area of primary health care, as a regulatory form of providing the services of a special public interest.

The concession allows the provision of health care services in the family medicine/general practice field, dental health care, health care for infants and preschool children, health care for women, laboratory diagnostics, chemist's services (in accordance with a special law), occupational health, and health care at home.

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58 Official Gazette of the Republic of Croatia, *Narodne novine* no. 169/04 and 37/08 (Decision of the Constitutional Court of the Republic of Croatia).

59 Presentation made by the State Secretary Drazen Jurković at a professional gathering in Zagreb, 3 June 2009

60 Official Gazette of the Republic of Croatia, *Narodne novine* no. 125/08.

The public health care service on the primary level of health care activities may be provided by private persons and health care institutions if they meet the conditions prescribed by the Health Protection Act. Trade companies may not provide the public health care service on the primary level, on the basis of concession.

The grantor, i.e. the giver of the franchise, is an entity, i.e. the legal person authorised to grant concessions.

The concessionary is a private or legal person with whom the concession grantor has signed the contract on concession. The contract on concession contains the regulations on mutual rights and regarding the granted concession. The concession register is a unique electronic record of contracts on concession granted in the territory of the Republic of Croatia. The bidder is a legal or a private person that has submitted an offer in the procedure for granting a concession.

The procedure of concession granting consists of the preparatory actions for granting the concession, of the notification on the intention of concession granting (public bid), the decision on selecting the best bidder, obtaining the consent of the Ministry of Health and Social Welfare and stipulating the contract on concession.

A concession for the provision of public health care services in the area is given by the local/regional self-government units, whose task is to make a preliminary estimate of the concession value, carry out a feasibility study, appoint an expert committee for concessions and generate documentation for competition.

The local/regional self-government units need to provide health care accessibility in their area through completing the network of public health care services in their area, through organising the activities of institutions which they have founded, coordinating the activities of all the legal and private persons who provide health care services in the area of respective local/regional self-government units, and, in accordance with the public health care services network, they need to grant concessions for the provision of the public health services in their area.

Concessions for the provision of public health care services are not only regulated by the Act on Concessions or by the Health Protection Act, but also by other regulations: The Public Procurement Act[61], the Act on General Administrative Procedure[62], by-laws, i.e. the acts issued by the government (acts, decisions), and the public administration central entities (rules of procedure, decrees, instructions) and the general acts issued by entities in units of local/regional self-government, municipalities, towns, counties, the City of Zagreb (statutes, decisions, rules of procedure). The contract with the Croatian Institute for Health Insurance (HZZO), as well as a proof of disposing of the premises for the provision of services is also necessary.

Many issues are raised in regard of the procedure of concession granting. For instance: whether a guarantee for the seriousness of the bid (the Act on Concessions), which implies a money deposit, will be implemented. The deadlines are basically very short – the deadlines for submitting the bid and for making a decision on selecting the best bidder are 30 days. Moreover, one needs to bear in mind that the contract on concession may not be signed until the 15-day off period has expired. The total of all deadlines is 75 days, so there are many sceptical comments about whether it is possible to make a bid and grant a concession within the period of time regulated by the Health Protection Act, i.e. until the end of this year.

[61] Official Gazette of the Republic of Croatia, *Narodne novine* no. 110/07 and 125/08.
[62] Official Gazette of the Republic of Croatia, *Narodne novine* no. 47/09.

There is also an issue of effectuating legal protection, which should be implemented in accordance with the rules that regulate public procurement, etc.

The concession grantors are requested to realise a difficult task of implementing the complex procedure of concession granting. Furthermore, there is no defined or unified model of procedure, which may result in various interpretations in implementing the rules, and the prescribed deadline for implementation may be too short, taking into account all the deadlines prescribed by the laws.

The complexity of legal regulations of concessions and specificity of organising the provision of health services in the PZZ indicates the need for enacting a special directive that would accurately and integrally regulate this issue.

The Council for Health is a new term in the Croatian health care system and a novelty in the health care legislative. It was introduced by the Health Protection Act (ZZZ); no similar body has existed so far. Taking into consideration its definition as "[...] the entity founded at the body of local/regional self-government in order to effectuate the rights, duties, tasks and goals in the health care area in the respective region", it may be said that this is a new advisory body established at the level of local/regional self-government, with prerogatives in the field of development of a health protection plan and accessibility of health protection in the respective regional unit.

Rationalisation of the network of hospitals

The reform only affects the hospitals in the City of Zagreb, which is the most frequently criticised element of the rationalisation.

The average distance from one hospital to another in Croatia is 36 kilometres, whereas the European standard is 77 kilometres. Although the employers do not associate the income deficit in hospitals with their number, the fact is that 64 hospitals represent a large financial burden, given that their operation is financed by public means. The total income of all the hospitals in Croatia last year amounted to HRK 11.2 billion, a bit less than half of the total health care budget or one tenth of the state budget. Out of this amount, HRK 6.1 billion is the income of clinical hospital centres, clinical hospitals and clinics, whereas the general hospitals made a revenue of HRK 3.8 billion last year, and the specialised hospitals earned HRK 1.2 billion.

Number of hospitals around the counties

17 – City of Zagreb

6 – Primorje-Gorski Kotar county

4 – Krapina-Zagorje and Varaždin counties

3 – Karlovac, Zadar and Požega-Slavonia counties

2 – Zagreb, Sisak-Moslovina, Bjelovar-Bilogora, Brod-Posavina, Osjek-Baranja, Vukovar-Srijem, Istria, Šibenik-Knin, Split-Dalmatia and Dubrovnik-Neretva counties

1 – Lika-Senj, Koprivnica-Križevci, Virovitica-Podravina and Međimurje counties

The business operation analysis of 64 hospitals in Croatia has shown that almost a third of them, i.e. 21 hospitals, have an income deficit. The income deficit was presented by five clinics, ten general hospitals and six specialised hospitals last year. In the opinion of the Health Care Employers Association, a detailed analysis of income and expenditures should be made, in order to find the causes for problems in business operation.

Perhaps even more important than the number of hospitals itself is the issue of their distribution and structure – expensive equipment is not fully used, operation theatres are not optimally utilised and the numbers of patients per expert team are way below the average.

There are four clinical centres in Croatia: Zagreb, Rijeka, Split and Osijek, and they represent the principal regional centres. There are also three clinical hospitals in Zagreb (Dubrava, Merkur and Sestre milosrdnice), whereas out of seven clinics, there is only one situated outside Zagreb and that is the Orthopaedic Clinic in Lovran.

The rest of the network consists of 27 specialised hospitals and 23 general hospitals, which are situated around Croatia in different density. There are 17 county hospitals in continental Croatia, and 6 general hospitals in the coastal counties. There are 46 hospitals in continental Croatia, and the remaining 18 hospitals, including Gospić and Knin, are mostly located along the coast, from Rovinj to Dubrovnik.

Apart from the above-mentioned clinical centres and a general hospital (Sveti Duh), as well as the six specialised hospitals, the City of Zagreb is beyond doubt the leading medical centre and, when taking into account the institutions, there are even 17 hospitals indicated on the city map of Zagreb. One can also add to this figure the two specialised hospitals in the Zagreb County.

This area has an impressive number of hospitals. Another proof of it is the neighbouring Krapina-Zagorje County where one of the most modern hospitals in the country is located – the general hospital Zabok. There are also three specialised hospitals in this county, including a private specialised hospital for cardiac surgery and cardiology, "Magdalena" in Krapinske Toplice. Generally speaking, the area of central Croatia is an area with the largest number of hospitals and with highly specialised institutional health care.

In the area of Slavonija there are ten hospitals. Alongside the clinical hospital centre in Osijek, there are eight more county hospitals located in Virovitica, Pakrac, Požega, Slavonski Brod, Nova Gradiška, Našice, Vinkovci and Vukovar. There are two general hospitals per county.

The situation is somewhat different on the coast, where there are two clinical hospital centres in Rijeka and Split, and there are also five county hospitals in Pula, Zadar, Šibenik, Knin and Dubrovnik. The distance between these hospitals is in some areas much bigger than the Croatian average, hence it is often mentioned that there is a 200 kilometres distance between the Split and Dubrovnik hospitals.

The question whether it is really necessary to have this large number of hospitals with such spacing indicates the question whether Croatia needs this number of municipalities and towns. The experts are reluctant to give an appropriate answer. The fact is that a reorganisation is necessary.

The Ministry of Health and Social Welfare has for a long time been announcing the drafting of a master plan for hospitals that should define their optimal number, as well as their structure. The master plan implies the introduction of a quality system and the categorisation of hospitals, which is scheduled to begin next year. After registering the equipment, premises and staff in the hospitals, the expected system of functioning and providing health care should prevent the current trend of hospitals in some counties developing under the principle of 'independent islands'.

Reform of the Emergency Medical Service

In accordance with the National Strategy of Health Care Development 2006-2011, the reform of the emergency medical service is one of the most significant parts of health care reform.

The aim is to have a better-quality, more accessible and more evenly organised emergency medical service for all the citizens of Croatia.

The current organisation of the ambulatory emergency medical service consists of 4 Institutions for Emergency Medical Service (jurisdiction of over 17% of the Croatian territory, providing care for 40% of Croatian population). There are also 82 emergency medical service units at the health centres. The secondary and tertiary levels do exist in hospitals, but individually within the hospital services, and exceptionally in the unified emergency hospital admission.

The emergency medical service reform was foreseen to take place in stages. The Croatian Emergency Medicine Institute has been established. However, the 21 county institutes for emergency medicine have not been established yet, and neither has the unification of emergency hospitals admission been effectuated. The organisation of unified emergency admission in the health centres in the hard-to-reach areas, as well as in the areas remote from the hospitals, has not taken place either.

The average time between receiving the call and arriving to the intervention location is 17 minutes in the urban area, whereas it is 60 minutes in the rural area. The reform goal in the next 5 years is to achieve a waiting time of 10 minutes in 80% of the cases in the urban area, and 20 minutes in 80% of the cases in the rural area.

The average time between receiving the call and arriving at the emergency hospital admission is 100 minutes, and the reform goal in the next 5 years is to have 80% of cases treated within an hour.

The following activities should be implemented in the forthcoming period, as it has been announced by the Ministry of Health and Social Welfare

- Separating the medical transport from the emergency medical service
- Carrying out 24-hour home visits by the family medicine doctors
- Establishing the 21 county emergency medicine institutes
- Setting up login-alarm units according to the county model
- Establishing the unified emergency hospital admission

All of this is necessary, in order to accomplish the goals of the emergency medical service reform, which are as follows: efficiency improvement of the emergency medicine system, increase in coordination of service standard on the county level, increase in reacting efficiency and velocity of the ambulatory emergency medical service, efficiency improvement of emergency hospital admission.

2.2.2 Overview of debates / political discourse

Health reform continues with further rationalisation plans and cutting of expenses. The short-term activities in the Government Economic Recovery Programme are formulated as follows:

1. Continuation of health care reform by rationalising the activities and networks of health institutions
2. Limiting the number of beneficiaries of the additional health insurance paid by the state
3. Completion of the informatisation of the primary health care
4. Networking the hospital system with a central health care information system.

Mid-term activities include:

1. Expansion of market activities of the Croatian Health Care Institute – HZZO (travel and additional insurance)
2. Rationalisation of operation of medical institutions and continuation of implementing the remaining reform measures
3. Completion of the accreditation and categorisation of the hospital system.

The Ministry of Health and Social Welfare has proclaimed the rationalisation and amplification of effectiveness and accessibility of the health care services as its primary goal. This includes the enhancement of liquidity of hospitals, efficient management and reduction of members of the management boards in hospitals, reduction of administrative staff, rationalisation of expenses of technical staff (outsourcing, spin-off), rationalisation of emergency medical services and unification of public procurement procedures, as well as continuation of informatisation (e-prescriptions, e-referral to specialist medical examinations, e-medical records and e-ordering for medical examinations).[63]

The leading opposition political party, SDP, claims that the change in payment of additional health insurance (i.e. reduction of number of beneficiaries entitled to free additional health insurance) means yet another transferring of health care financing from the state to its citizens and that constant changes in this segment mean that the government does not really have a clue as to how to resolve the outstanding issues.[64] Although not denying that the citizens in most European countries spend much more on health care, SDP claims that such higher contributions result in higher level of services, which is not the case in Croatia. The only benefit for Croatian citizens is exemption from payment of participation for basic health insurance. The leading opposition party is not alone in claiming that the 'latest' reform is just a show for the public, because the proposed measures will result in minimal savings when compared to total expenditures in the health care system, which are around HRK 20 billion.

The unions have also reacted negatively to the entire Government Economic Recovery Programme, including the cutting of entitlements in health care, and are demanding to be included in the process of drafting implementation measures,[65] so far to little avail.

As regards the new system of concessions in primary health care, the Coordination of the Croatian Family Medicine (KoHOM) hoped that they would be able to postpone the introduction of the concession, as they point out that, among others, the following questions have not been resolved: who is going to pay the substantial bid costs to the physicians whose profession is not profit-bearing and who receive only the capitation for their patients; how are they going to work if, due to failing to effectuate the non-defined obligations, the bond that actually guarantees the right of effectuating the concession contract duties with HRK 10,000; the condition for obtaining the franchise is paying a nurse in accordance with the health care collective agreement, whereas the family medicine practices are responsible for less than 1,500 insured persons, who account for around 40% of the patients, do not have their funds in the capitation that enable them to do so, etc.

The KoHOM believes that the physicians cannot be expected to sign a concession contract until they are fully informed of their duties and whether they will be able to fulfil these duties,

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63 Nastavak reforme zdravstvenog sustava u sklopu gospodarskih mjera (Continuation of health care reform within measures economic recovery), ppt presentation, retrieved from: http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/reforma_zdravstvenoga_sustava

64 Retrieved from: http://www.index.hr/vijesti/clanak/koliko-jos-prije-nego-sto-nas-bolest-pocne-dovoditi-do bankrota/488177.aspx

65 Independent Croatian Unions, press release, retrieved from: http://www.nhs.hr/novosti/novost.aspx?id=2985.

how much they will be paid, who will renovate the premises and equipment in the practice, etc.[66]

2.2.3 Impact assessment

Perhaps the most accurate remark about the current situation in health care is provided by journalist Nataša Škaričić: the overall public impression is that health care is in constant state of reform, but each transformation leads to even worse conditions and less accessibility for the beneficiaries.[67] Since 2003, health administration has had 11 legislative interventions in the legislation on mandatory and voluntary health insurance, and the decisions on the manner, scope and amount of health participation and administrative levies have been adopted and revoked even in periods shorter than one year. Each 'reform' was basically concentrated on amendments to health protection legislation which concern the system of additional payments of health services. Regarding the rationalisation of the network of hospitals, the main criticism is that it is focused on hospitals in Zagreb and not the entire network. At the same time, a number of local hospitals in areas of special state concern are not appropriate to the real needs of the population in those areas and their capacities are not utilised adequately.

The impact of introduction of concessions in primary health care is much debated. While the representatives of the family physicians claim that many of them will have to close their already unsustainable practices, the representatives of the unions claim that they, in fact, conduct very profitable practices, which will now also have to be paid directly by the users.[68]

Cutbacks of the additional health insurance mean that in the future as many as 360,000 beneficiaries will incur out-of-pocket costs for each service in primary health care, in the amount of HRK 15 for each service: a visit to the physician's surgery, a recipe as well as any referral to specialist examinations. Should hospital treatment be required, the patients without additional health insurance bear the cost of each service rendered to the amount of 90% of its actual cost, but not more than HRK 3,000. This could accentuate inequalities regarding access to health care.

2.2.4 Critical assessment

As expected, the announcement of cutbacks of additional health insurance caused extremely negative reactions in the public. Around 360,000 beneficiaries are set to lose the right to free additional health insurance, financed by the state. This number includes around 100,000 disabled persons with 80% disability, war veterans with disability of at least 30% and a large number of unemployed persons. The number of disabled persons – war veterans and their families entitled to this benefit will be reduced to about 10,000, which is ¼ of their previous number. This entitlement will remain unconditional only for regular pupils and students, disabled persons with disability of 100%, organ donors and long-term voluntary blood donors. Means testing will be applied to all the other population, with the benchmark set at HRK 1,516.32 per family member. The Minister of Health has highlighted that this system is fairer and directed at those who are really in need of such benefit.[69] According to the data from 2008, there were 1,247,280 beneficiaries of additional health insurance whose policy was paid from the state budget. This number should be reduced to 883,329 beneficiaries, which means

66 Physicians' Newspaper, Number 4 /November 2009.

67 Nataša Škaričić: 'Milinović sebi kupuje vrijeme, a nama troši novac', retrieved from: http://www.tportal.hr/vijesti/hrvatska/65550/Milinovic-sebi-kupuje-vrijeme-a-nama-trosi-novac.html.

68 Article published in the daily newspaper Novi list of 29 March 2010.

69 Newspaper article published in daily newspaper Novi List of 27 April 2010.

a saving of HRK 350 million. While this may contribute to the *sustainability of the health care system*, as one of the OMC objectives, the *access to and quality of health care* might be negatively affected as a result of this measure.

The total saving that the Ministry of Health and Social Welfare expects from rationalisation of the network and increased efficiency should reach HRK 318.5 million. A large proportion of savings should be contributed by the unification of the system of public procurement for medicines and consumables, technical services outsourcing should bring additional HRK 100 million of savings, and HRK 30 million in the 5-year period should be achieved by the reduction of administrative staff by 20 to 30%.[70]

Although the Minister of Health and Social Welfare highlights the benefits of the concentration of resources for patients, and claims that the reform is based on Austrian experiences, the prevailing mood among patients is that of disorientation and confusion. It does not help either that the transparency is very low[71]: the team of experts behind the reform is unknown, there is no serious professional debate concerning the proposed reforms and their impact, which could eventually lead to finding constructive alternatives for some of the reform goals, no coherence with other strategic documents[72] and, most importantly, *information gaps* are obvious: there are no written strategic documents containing projections and analyses of impacts, detailed criteria, level of desired protection and quality assurance mechanisms. The Ministry of Health and Social Welfare has presented the reform, the preliminary results of the reform, and the activities for continuation of the reform in light of the Economic Recovery Programme *in the form of colourful PowerPoint presentations*, available on the website of the Ministry.[73]

The World Bank has welcomed the proposed reforms. The newest health reform is completely in line with its projections and recommendations, according to the published Country Partnership Strategy in the period from 2009-2012,[74] which could entail another loan to Croatia. The World Bank has acknowledged that "[...] *Croatia's health outcomes are better than in many countries at similar income levels, but these results were achieved at a high cost. [...] continued deficits affect the sustainability of the system.* [...] *An ageing population and limited financial resources have made a social system reform unavoidable*".[75] The involvement of the World Bank in yet another reform of the health system in Croatia appears inevitable and is, of course, conditional upon the reduction of expenditures for health care.

Transparency is very low: medical associations often criticise the Croatian Institute of Health Insurance for not taking account of their positions and comments when drafting implementing acts and contracts with practitioners. Most recently, the Croatian Medical Chamber, in association with other associations of medical doctors in primary health care, has issued a

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70 All estimates are laid out in the ppt presentation by the Ministry of Health and Social Welfare (see footnote 53).

71 Newspaper article published in the daily newspaper Novi List of 04 April 2010.

72 Notably, the National Strategy for Development of Health Care 2006-2011, adopted in Croatian Parliament in June 2006, Official Gazette of the Republic of Croatia, *Narodne novine* no. 72/2006.

73 hese include the following presentations, in order of their appearance (from the most recently published one): Nastavak reforme zdravstvenoga sustava u sklopu gospodarskih mjera (Continuation of health care reform within the framework of economic measures); Što je reforma donijela pacijentima (What has the reform brought to the patients?); Prvi rezultati reforme zdravstva za medije (The first results of the health care reform for the media), all retrieved from: http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/reforma_zdravstvenoga_sustava (The original *PowerPoint* presentation of the health care reform has since been removed from the website).

74 World Bank. Croatia: Country Partnership Strategy for FY09-FY12. Annex 1: Results Matrix; retrieved from: http://siteresources.worldbank.org/CROATIAEXTN/Resources/croatia_cps_annex1.pdf

75 World Bank. Croatia: Country Partnership Strategy for FY09-FY12, Full report, 6-7, retrieved from: http://siteresources.worldbank.org/CROATIAEXTN/Resources/croatia_cps_development_challenge.pdf

communication, in which they advise physicians in primary health care not to sign the agreements for provision of primary health care offered by the Croatian Institute of Health Insurance, due to their ambiguity and the fact that many issues have remained unresolved.[76]

Another important issue which deserves attention, but is unfortunately not high on the agenda is the development of hospices and other institutions for palliative care. Currently, there are no such institutions in Croatia, since there is no legal framework for their establishment, even though the concept of palliative care is recognised and entered into the Act on Health Protection in 2003. An initiative for the establishment of the first institution of palliative care has recently been presented by the Croatian Society for Palliative Care and the Croatian Committee of Medical Doctors. These organisations are based on public-private partnership. However, given the importance of this issue, greater involvement of the state is needed and an appropriate legal framework for it should be devised.

2.3 Long-term care

2.3.1 Overview of the system

Long-term care in Croatia is organised within the system of social welfare, at the national as well as the regional level. The legal framework for social benefits includes the Social Welfare Act,[77] the Foster Families Act[78] and numerous by-laws. The two basic categories of recipients of social assistance and welfare are those who do not receive any income or whose income is below the prescribed census, on the one hand, and persons who receive assistance in order to satisfy their personal specific needs, resulting mostly from disability, old age, psychological conditions, addiction etc. (including children and young persons without parental care, children and young persons with behavioural disorders and victims of family violence) on the other hand.[79]

Long-term care is organised on the principle of social assistance and financed through state and local budgets. It is directed towards persons who are dependent on help with basic activities of daily living, caused by chronic conditions of physical or mental disability. Pursuant to Article 10(2) and (3) of the Social Welfare Act, the beneficiary receiving social welfare is defined, amongst others, as a single person or a family member (or the entire family), who is an adult with physical or mental disabilities, or frail elderly, person incapable of looking after themselves or another person who is not able to fulfil their vital needs, due to permanent or temporary changes in health conditions.

The benefits include benefits in kind and cash benefits.

An allowance for assistance and care, for example, is granted as a cash benefit to the persons unable to care for themselves, on a permanent or temporary basis. Means testing is applied, meaning that a person is eligible for this kind of assistance if their income in the three months preceding the application does not exceed 200% of the base amount (per family member) or 250% of the base amount (single persons).[80] According to the latest available data for March

[76] Communication in Croatian, retrieved fromt: http://www.hlk.hr/Download/2010/05/14/Priopcenje.pdf

[77] Official Gazette of the Republic of Croatia, *Narodne novine* no. 73/97, 27/01, 59/01, 82/01, 103/03, 44/06, 79/07.

[78] Official Gazette of the Republic of Croatia, *Narodne novine* no. 79/07.

[79] Babić, Z. Uloga socijalne pomoći u politici prema siromaštvu u Hrvatskoj (The Role of Social Welfare in the Policy against Poverty in Croatia), *Privredna kretanja i ekonomska politika* 116/2008, Ekonomski institut, Zagreb, 2008, pp. 53 – 81, 64.

[80] Social Welfare Act, Article 43(1).

2010, a total of 79,848 persons received this allowance, out of which 54,286 received the full amount, and 25,562 received 70% of the full amount of allowance.[81]

Currently, the basis for the realisation of social welfare rights amounts to HRK 500 and is determined under the decision on the basis for the implementation of the social welfare rights.[82] This amount represents an increase by HRK 100 in comparison to the previous amount of HRK 400 (which was applicable from 2001 to 2008) and has applied as from November 2008. This increase is based on the Strategy for Reform of Social Benefits for 2007 and 2008 proposed by the Government.

In-home assistance (including delivery of meals, housework, and assistance with personal hygiene) to persons having no other assistance from their family members is an example of the administered benefits in kind.[83]

There also exists a range of institutionalised forms of care, e.g. permanent or temporary accommodation or even daily or shorter stays in care centres.

Elderly people mostly rely on permanent assistance, supplement for assistance and care at home and personal disability allowance.

2.3.2 Overview of debates / political discourse

The goal of the Economic Recovery Programme is to increase the efficiency of social transfers by directing them exclusively to persons in need. Envisaged short-term activities include:

- Analysis of the system of social benefits, equalisation of benefits acknowledged on the same basis and full implementation of PIN (personal identification number or OIB) as a steering instrument for social policy measures;

- Development of a coordinated network of the system of social transfers at all levels of governance.

The new Social Welfare Act is expected to be adopted by the end of 2010. However, the reform of the social welfare system always seems somewhat neglected, as constant changes in health care provoke greater attention of the public. The Social Welfare Union has recently strongly criticised the Ministry of Health and Social Welfare, claiming that their union, as well as the entire profession are systematically marginalised and their professional development neglected.[84] They even demand that social welfare should be separated from the Ministry of Health and Social Welfare, and be organised as part of another portfolio within the government. Lack of transparency of the reforms in the field of social welfare is also criticised, due to the fact that those who are supposed to implement it, i.e. workers in social welfare, are unaware of its goals, the roles of different actors, they lack even the basic information, there are no documents explaining the effects of the reforms. Measures are taken without taking into account the views of those directly in contact with the beneficiaries, to the extent that they are perceived as dictates from the ministry. They point out that there are 80 centres and 30 regional branch offices with 2,100 employees, who are responsible for

81 Monthly Statistical Report, March 2010, Ministry of Health and Social Welfare, retrieved from: http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/mjesecna_izvjesca_2010

82 Official Gazette of the Republic of Croatia, *Narodne novine* no. 30/08.

83 Social Welfare Act, Article 50(1).

84 Article published in electronic issue of the daily newspaper Novi List of 22 March 2010, retrieved from: http://www.novilist.hr/2010/03/22/gdje-je-nestalo-466-milijuna-eur.aspx

ensuring professional treatment of different sensitive issues in society, including the issues of elderly persons. The union has also emphasised the difficult position of employees, given that there is only one social worker covering 10,000 persons or 200 families on average.

Deinstitutionalisation of social services is one of the priorities of the government within the Joint inclusion memorandum (JIM) implementation project. A number of scenarios for achieving this goal and results of research conducted at the level of different institutions have been presented at a conference held in Zagreb on 11 February 2010.[85]

2.3.3 Impact assessment

The lack of hospices and institutions for palliative care is particularly affecting the long-term care for elderly. Namely, the profile of the users of homes for the elderly has significantly changed. Some assessments show that nearly a third of beneficiaries in the homes for the elderly are gravely or terminally ill[86], which means that those institutions have turned into care homes, institutions for providing palliative care and medical treatment, which is not their original purpose. The professional circles highlight the manifest need for an organised system of palliative care and hospices. It should be implemented within the health system, with a dominant role of the state.

There is a chronic lack of institutional facilities (homes for the elderly). There are waiting lists for accommodation in those facilities; capacities are overbooked and the average usual waiting period is one year.[87] Some professionals are proponents of private-public partnerships as a solution for these issues. However, there is a question of accessibility of privately financed institutions for elderly without income or with insufficient income. The average monthly cost of a beneficiary for accommodation in publicly financed facilities is HRK 2,000 (EUR 274; almost equal to the sum of the average pension), while the rest is co-financed by the counties (who are founders of the homes for elderly). The cost of accommodation in private homes could be up to 2 or 3 times higher. The issue of capacity for reception could be partially dealt with through an efficient system of home and informal care (further on this subject under the next sub-heading). Research conducted by GfK Croatia shows that around 11% of households are seriously affected by the need to provide care for the elderly, vulnerable and/or ill family members.[88] These problems mostly affect households in Northern Croatia (14%) and in areas where the main source of income is agriculture (27%). 66% of the families affected claim that they care for their vulnerable family members themselves (as compared to 74% in 2004). 12% receive regular medical and/or other assistance outside the household, and only 9% have secured accommodation in a home for the elderly. 12% of the examinees have declared that they have a serious problem, with no appropriate solution. The last group mostly affects households in Zagreb (23%), households in settlements with more than 100,000 inhabitants (23%) and the region of Istria and Primorje (18%). The most households in which families take care of their members alone can be found in the Dalmatia region (80%).

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85 All presentations from the Conference retrieved from: http://www.mzss.hr/hr/medunarodna_suradnja/socijalna_skrb/jim_zajednicki_memorandum_o_socijalnom_ukljucivanju_rh/jim_jap_konferencija_globalna_kriza_i_njezin_utjecaj_na_republiku_hrvatsku/prezentacije/(offset)/10

86 REVIJA za socijalnu politiku, 16, 1 (2009), Note from the Conference: Hospice and Palliative Care – Fundamental Human Right, Zagreb, 10-12 October 2008.

87 Article published in electronic issue of the daily newspaper Novi List of 17 July 2009, retrieved from: http://www.novilist.hr/2009/07/17/na-listi-cekanja--BBspremno-AB-2.aspx

88 Retrieved from: http://www.gfk.hr/public_relations/press/press_articles/005551/index.hr.html

Another important element for the development of long-term care is average life expectancy. Average life expectancy in Croatia was 76 years in 2008, with a significant, and growing, difference in life expectancy between men (72.4) and women (79.6).[89] The average age of the population is 41 years. There is a slight increase in life expectancy as compared to 2007 (when average life expectancy was 75.8 – men (72.3) and women (79.2). Data for 2009 are not available as yet. As demand for long-term care rises with the increase of life expectancy, the aspect of prevention of ill health within the health system should be emphasised. A preventive approach should lead to an increase of healthy years and loosen the demand for long-term care. However, better coordination and coherence between health and long-term care services is needed, and should be further developed.

According to the World Bank report on the status of projects in execution, FY09 SOPE for Croatia,[90] the project of Social Welfare Development, funded by a loan of approximately EUR 44 million, which was approved in 2005, is to be closed on 15 June 2010. The project objective was to strengthen the quality, targeting and administration of social benefits and services being provided to those most in need. The project is currently in the process of formal restructuring in order to revise the objective and key indicators to align them more closely to project activities. Progress towards meeting the proposed revised development objective has been positively evaluated by the World Bank: all implementation milestones have been achieved. The share of residential social institutions for children and adults that meet public standards has increased to 73%. New policy planning and system development tools such as quality standards, social planning and methodological centres have been developed and implemented in the pilot counties. New management information software has been developed and tested.

2.3.4 Critical assessment

It is to be expected that the new Social Welfare Act will provide an adequate legal framework towards the increase of the system's efficiency, simplification and transparency. The activities should, however, include development of technical and other capacities which could contribute to the accomplishment of the stated goals. Appropriate application of PIN and cross-comparability of different records and registers, as well as cooperation between different authorities at central, regional and local level is essential to avoid duplication of benefits, and to ensure that they are received by those who really need them. For example, there is currently no cross-comparability of the records on ownership of real estate, with those on social benefit recipients. It could happen that persons who own several real estate properties use social benefits of some kind, when they could clearly sustain themselves from their own assets.

Another aspect of the long-term care for elderly is completely neglected by the state. Namely, family solidarity, i.e. taking care of the elderly by other members of the family, is taken for granted. The status of a care-giving family member should be recognised and facilitated. However, finding an appropriate mode for fostering this type of family solidarity, through tax incentives, a system of cash and in-kind benefits, adjustments in employment relations (carers are usually children of the elderly person in need of care, who are still employed), etc. is not

[89] Croatian Bureau of Statistics, Monthly Statistical Report no. 3/2010, year XIX. See also World Bank Data and Statistics for Croatia: http://www.worldbank.hr/WBSITE/EXTERNAL/COUNTRIES/ECAEXT/CROATIAEXTN/0,,menuPK:301270~pagePK:141132~piPK:141109~theSitePK:301245,00.html

[90] STATUS OF PROJECTS IN EXECUTION – FY09 SOPE, EUROPE AND CENTRAL ASIA REGION COUNTRY: CROATIA, Operations Policy and Country Services, 2 OCTOBER 2009.

the focal point of discussions at the moment. Facilitated home care could reduce the demand for institutional services, which surpasses supply by dozens of times. This task would be challenging, given the plans to abolish almost all kinds of tax reliefs in the system of personal income, as commented above, but should not be left out without any consideration. The provision of home and community/residence care should be expanded and fostered together with the implementation of quality insurance mechanisms, for example through obligatory care consultancy, in-home visits by supervisors, free care courses etc. As stated in the previous sub-heading, over 150,000 households in Croatia are in need of an organised approach and assistance when it comes to home care for the elderly.

Long-term care should not be based exclusively on private financing, even though private sources should also play a role in ensuring financial sustainability of the system. Public-private partnerships are one option, but private financing is often reserved for those with higher income and does not cover the needs of the most vulnerable group, i.e. elderly without income. Prevalence of private financing would negatively impact the accessibility of long-term care.

Within the overall reform of the social protection systems, modalities for introducing the concept of a long-term care insurance in the Croatian legal framework should be examined.

3 Impact of the Financial and Economic Crisis on Social Protection

Although the financial and economic crisis has not hit Croatia as hard as some of the countries in its surroundings and the rest of Europe, its impact is obvious throughout different sectors. The Croatian financial and economic crisis is not merely a reflection of global trends, but rather independent and rooted in different reasons of its own. This is now evident from the fact that globally, some signs of recovery have already started to appear in the second half of 2009. Meanwhile in Croatia, the recession still firmly persists. The more optimistic forecasts predicted that Croatia will begin the road to economic recovery in this period as well; however, the second half of 2009 and the first quarter of 2010 actually brought aggravation: the registered unemployment rate reached its peak in March 2010, with 18.4%. The most vulnerable group are young employees, who first enter the labour market, as well as those up to the age of 34.

One of the reasons for the prolonged grasp of the recession could lie in the fact that the real reform efforts are yet to be seen. In our previous annual report, we expressed our doubts regarding the effects of the government stimulus package containing 10 anti-recession measures, adopted on 26 February 2009. It proved to be nothing more than a collection of wishes; the majority of measures never came to life (apart from three budget rebalances in 2009).

During 2009, a number of 'first-aid' measures for salvaging the state budget and fighting its deficit were implemented:

- three state budget rebalances;
- increase of the rate of value added tax from 22% to 23%;
- introduction of the special or so-called 'solidarity' tax on net income (salaries, pensions and other income, including the income earned in independent professions);
- temporary suspension (until the end of 2010) of the pension adjustment;
- wage cutbacks and suspension of wage growth for civil and public servants;
- abolition of the programme which guaranteed the right to free textbooks in primary education.

All of these measures brought only temporary relief for the budget, while the impact of some of them (notably the introduction of the special tax on net income) is largely disputed. Personal consumption dropped, real GDP is down by 5.8% in 2009 as compared to the previous year.[91] Croatia has one of the lowest employment rates in Europe.[92] This is one of the crucial reasons which limits economic growth and has a significant impact on the social protection system. Further growth of unemployment is the greatest risk factor.

On 19 April 2010, the government announced a new Economic Recovery Programme.[93] The programme itself represents a kind of a strategic document, identifying key areas which require urgent action and activities to be taken to reach the proclaimed goals in the short,

[91] According to the data available from the Croatian Bureau of Statistics, retrieved from: http://www.dzs.hr/

[92] At an average of 43% in 2009, according to the preliminary data published by the Croatian Bureau of Statistics, retrieved from http://www.dzs.hr/ (Employment/population ratio refers to persons in employment as a percentage of the working-age population (15+)).

[93] The Programme is available on the website of the Government of the Republic of Croatia, retrieved from: http://www.vlada.hr/hr/naslovnica/novosti_i_najave/2010/travanj/predsjednica_vlade_predstavila_program_gospodarskog_oporavka

medium or long term. It was drafted by an *ad hoc* team of 4 economic experts, predominantly private entrepreneurs, including the Head of the Croatian Institute of Economics. The underlying goal of the programme is economic recovery and establishment of a competitive economy with high standard and quality of living. The declared principles for achieving this underlying goal are stability (stable economic growth, based on production growth which includes alleviating macroeconomic imbalances, especially the gradual decrease of foreign debt and fiscal deficit), sustainability (economic effects of demographic changes, prudent use of space and environment protection) and social justice (ensuring dignified living, especially for the most vulnerable categories of the population – unemployed, poor, persons with special needs and elderly). The government's declared ambition is to provide the basis for a thorough transformation and not only a package of 'first-aid' measures, using five key levers:

1. Decrease of public sector expenditures, alongside an increase in work efficiency and transparency

2. Redirection of budget funds from irrational consumption towards target social transfers and economically justified capital investments

3. Decrease of involvement of the state authorities into the economic trends: by further privatisation and the professionalisation of the management of public companies and state institutions, in accordance with the principle of prudent management

4. Initiation of a new investment cycle with economically measurable long-term effects, with maximum participation of the private sector

5. Acceleration of implementing the reforms in: the judiciary, health care system, pension insurance, state and local management

The Economic Recovery Programme has provoked mixed responses in professional circles as well as in the general public. The majority agrees that urgent action is needed and even long overdue, but opinions differ when it comes to actual operationalisation of the set goals. The main concern is that the programme is a collection of ideas and concepts, written by economic experts and entrepreneurs, whose operationalisation is highly questionable, due to political reasons. Another objection is that it arrives too late, as too much time has already passed. For example, in order to foster foreign investment, a cross-sector working group will be set up, whose task will be to identify existing obstacles for direct foreign investments by the end of the year and to make a plan for their alleviation. Given the fact that the investors have been pointing to a number of difficulties affecting the investment climate for years, the effectiveness and cost-benefit justification of setting up this working group is highly debatable and could mean just another delay. The political parties which represent the opposition to the governing coalition claim that the programme is just another political and pre-election deception, which will ultimately mean the sacrifice of the most vulnerable and low-to-middle-income population, who will be forced to bear the greatest burden. Economic expert Dr Katarina Ott from the Institute for Public Finances warns that the programme lacks specification of the responsible persons or entities for implementation of specific activities, clear time schedules and a list of assignments, expenses and the source of assets for its implementation.[94] Some of the proposed activities are expensive (e.g. environment protection, infrastructure development aimed at fostering investment) and it is not quite clear how they will be financed.

The structural weakness of the Croatian economy is closely related with the issues of high external indebtedness and fiscal deficit due to high public spending. The external debt reached

[94] Ott, Katarina, Kojoj vladi vjerovati? (Which Government to trust?), Institut za javne financije, Aktualni osvrti br. 20, 22 April 2010, retrieved from: http://www.ijf.hr/osvrti/20.pdf

EUR 44.6 billion by the end of last year (which is about 11% higher than in 2008), representing 98.5% of GDP. Cutting budgetary expenses, in order to decrease the budget deficit is one of the necessary measures. This, however, means painful cuts in the field of social protection as well. The Government Economic Recovery Programme envisages a gradual reduction of the share of state income and expenditures in GDP by 3 percentage points in a 10-year period, i.e. by 2020. In its press release of 21 April 2010, the Croatian National Bank welcomed the Government Economic Recovery Programme, but warned that a quick economic recovery and trend change requires the implementation of the reduction much before 2020.[95] The Croatian National Bank warns that the previously implemented growth model based on fast domestic consumption growth has been exhausted and its continuation proved unsustainable even in the short run. Given that sustainable growth can be achieved through much greater focus on goods and services export, radical structural reforms, taxation changes and relieving tax burden, measures aimed at lower unit labour costs and increased competitiveness of Croatian products are required.

A number of economic experts warn about the fact that many programme measures require immediate implementation, but they are too general and their effects on budget and public sector financing needs, especially in this year's budget are still unclear. Another problem is that the Croatian government has issued two completely opposite documents in a very short period of time: the first was the Guidelines for Assistance to Entrepreneurs in Difficulties, published on 15 April 2010 and the second the Economic Recovery Programme, published on 19 April 2010. As rightly observed by Dr Ott,[96] the idea behind the first document is to help entrepreneurs in difficulties through two types of support: complete or partial write-off of a debt towards the state and transformation of state claims into shares in capital, i.e. recapitalisation. Therefore, there is real possibility that the implementation of the guidelines could lead to an *increase* of the state's share in the economy, which is exactly *opposite* to what is proposed in the second document, the Economic Recovery Programme.

The planned abolishment of tax reliefs in the system of personal income taxation has already provoked criticism in public and professional circles. Namely, it means no tax reimbursement for those with mortgages, life insurance policies, voluntary pension insurance, additional health insurance, patients using private medical care and subtenants. This could demotivate citizens to save for the old age, but also stimulate a 'grey' economy, i.e. providing medical and other services without issuing invoice (since they will no longer be used to substantiate requests for tax returns). Thus, the state could lose a significant portion of income accumulated through value added tax on services.

Shortly before the deadline for submission of this Report, on 29 April 2010, the Institute of Economics issued a press release, at the occasion of publishing of the Croatian Economic Outlook Quarterly no. 42.[97] They estimate that 2010 will be another tough year for the Croatian economy, emphasising that the negative trend of economic activities is still present, although its intensity has weakened. This could mean that the bottom of the crisis will soon be reached and that there is a possibility for recovery to start in the second half of the year. The estimated drop in GDP in 2010 should reach -0.7%, while a slow and unstable recovery could start in 2011. Personal consumption is affected by unemployment and lower wages, and is not expected to enter the phase of recovery before 2011. A further decrease of the employment rate in 2010 is expected, with approximately 50,000 less workplaces. The real state budget

[95] CNB Press release following the announcement of the Economic Recovery Programme by the Government of the Republic of Croatia, 21 April 2010, retrieved from: http://www.hnb.hr/eindex.htm

[96] Ott, Katarina, op. cit.

[97] Press Release at the occasion of publishing of the Croatian Economic Outlook Quarterly no. 42, retrieved from: http://www.eizg.hr/Item.aspx?Id=617&lang=1

deficit could surpass the plan and reach up to 3.5% of GDP, given the slower filling of the budget and greater social expenditures. However, a number of parameters could still significantly impact the estimates, particularly the uncertain stability of the world economic recovery, the impact of the Government Economic Recovery Programme, as well as the progress of Croatian accession to the EU.

4 Abstracts of Relevant Publications on Social Protection

[R] Pensions

[R1] General trends: demographic and financial forecasts
[R2] General organisation: pillars, financing, calculation methods or pension formula
[R3] Retirement age: legal age, early retirement, etc.
[R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
[R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health

[H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
[H2] Public health policies, anti-addiction measures, prevention, etc.
[H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
[H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
[H6] Regulation of the pharmaceutical market
[H7] Handicap

[L] Long-term care

[R1; H1; L] BABIĆ, Zdenko, Redistribucijski učinci socijalnih transfera u Republici Hrvatskoj, Revija za socijalnu politiku, god. 15, br. 2, 151-170, Zagreb, 2008.
"Redistributive Effects of Social Transfers in the Republic of Croatia"

The paper analytically investigates the system of social transfers in Croatia and evaluates their impact on reducing poverty and economic inequality in Croatia. In the theoretical part of the paper, recent results from the economic research studies about the new role of social expenditure and social transfers in the new environment are presented. The conclusion is that there is space for improvement regarding the efficiency of the social transfer system.

[R1; H2; H4; L] KORDEJ-DE VILLA, Željka / STUBBS, Paul / SUMPOR, Marijana (eds.), Participativno upravljanje za održivi razvoj, 2009, Ekonomski institut, Zagreb.
"Participatory Governance for Sustainable Development"

The main purpose of this book is to point to a variety of subjects related to governance of sustainable development and to contribute to understanding and dialogue between various disciplines, because the concept of sustainability requires interdisciplinary approach. The central motivation of this book is to create the awareness that different governance and decision-making forms have a decisive impact on the quality of results and that the model of decision-making can either contribute to or prevent the accomplishment of targets of sustainability.

[R1; R2] RISMONDO, Mihovil, Hrvatski sustav mirovinskog osiguranja i europski socijalni model, in: Revija za socijalnu politiku 17 (1), p. 89-112, Zagreb 2010.
"The Croatian Pension Insurance System and the European Social Model"

In the paper, the author compares the legislation that regulates the Croatian pension insurance system with the obligations from acquis communitaire in the context of the harmonisation of the legislation in the process of the accession of the Republic of Croatia to the European Union (EU). The author is not merely limited to the formal adjustment of the Croatian legislation with acquis communitaire, but also questions the adjustment of the Croatian pension system with the European social model which is applied in the pension system area, and which derives from acquis communitaire, as

well as the practice in Western European countries. In the concluding part, the author determines the adjustment of the legislation that regulates the Croatian pension system with acquis communitaire, but also points out that a part of this system is not adjusted to the European social model.

[R2] LATKOVIĆ, Mladen and LIKER, Ivana, Analiza utjecaja parametara u kapitaliziranom sustavu mirovinskog osiguranja, in: Financijska teorija i praksa 33 (4), p. 445-461, Zagreb 2009.

"Sensitivity Analysis of Accumulated Savings in a Defined Contribution Pension System"

In this article the authors analyse the effect of parameters in the standard model for calculation of accumulated savings in a defined-contribution pension system. Three parameters affect accumulated savings in the standard model: saving duration, return of the pension fund and the growth in employee gross wage. By using a linear approximation, we calculated marginal contributions for small changes in the parameters of the standard model and analysed their relations for a set of referent parameters which are most suitable for the 2nd pillar pension system in Croatia. It is shown that the return of a pension fund has a major influence on accumulated savings, while the influence of the growth in employee gross wage is slightly smaller. We also calculated the influence of raising the contribution rate in the 2nd pillar on the accumulated savings in a simple scenario, in which that rate is raised by equal amounts over the whole of a saving period. These results allow easier planning of pension insurance in the defined-contribution system at a general level as well as at an individual level.

[R2] BAGARIĆ, Nevenka, Ostvarivanje prava iz mirovinskog osiguranja branitelja iz domovinskog rata – izmjene propisa, in: Hrvatska pravna revija 2, 2010, Zagreb, p. 59-61.

"Realisation of the Rights from Pension Insurance of the Veterans of the Croatian Homeland War – Change of Regulations"

The criteria and the mode of assessment of pensions of the veterans of the Croatian Homeland War were modified in the amendments to the Law on the Rights of the Veterans of the Croatian Homeland War and the Members of their Families. The paper analyses the amendments which will contribute to a decrease or even complete stop of the recognition of status of new beneficiaries of disability and family pensions to those categories.

[R2] BAGARIĆ, Nevenka, Povlaštene mirovine – uvjeti za stjecanje prava i određivanje mirovine, in: Hrvatska pravna revija 12, 2009, Zagreb, p. 76-87.

"Privileged Pensions – Criteria for Acquiring the Right to Pension and its Estimation"

Pensions granted under more favourable conditions in respect of the criteria prescribed by general provisions, the so-called privileged pensions, have been the subject of permanent discussions. There are discussions concerning their justifiability, payment costs, and groups of beneficiaries (mostly the members of the parliament and the Homeland War veterans). Several groups benefit from the right to pension under more favourable conditions compared with the rights prescribed by the so-called general regulations. Among the groups benefitting from such rights, the criteria for acquiring that right are different, and so is the procedure of pension estimation, and, thereby, the level of pensions.

[R4] ROTIM, Sanja, Pravne posljedice rada umirovljenika, in: Pravo i porezi 5, 2009, Zagreb, p. 46-58.
"Legal Effects of Work of Pensioners"

The Croatian economic reality compels many pensioners to search for alternative income other than pension, due to the fact that the amount of pension is insufficient for decent and dignified old-age living. Pensioners are entitled to temporarily give up the right to pension at any time, and decide to join the labour market and establish a status of active insuree within the pension insurance system. The paper analyses the legal effects and payment of contributions in accordance with the applicable regulations.

[R4] KNEŽEVIĆ, Nikola, Obavljanje djelatnosti kućne radinosti ili sporednog zanimanja umirovljenika bez obustave isplate mirovine, in: Pravo i porezi 5, 2009, Zagreb, p. 59-61.
"Cottage Industry or Additional Profession of Pensioners without the Suspension of Pension Payment"

The paper analyses the possibility of pensioners to perform paid professional activities based on work contract, in accordance with the Crafts Act. The pensioners, thus, have a very limited possibility to earn supplementary income in addition to the full amount of pension.

[H] Health

[H1] VONČINA, Luka et al, Health insurance in Croatia: Dynamics and Politics of Balancing Revenues and Expenditures, in: European Journal of Health Economics, volume 11, issue 2 (2010), p. 227 – 233.

Since 2002, the Croatian social health insurance system has undergone substantial reforms, initiated for the most part with the aim of addressing the perpetual financial deficits of the state health insurance fund. While the reforms focussed heavily on increasing the inflow of private funds into the health care system, underlying inefficiencies contributing significantly to poor financial performance have been largely ignored. Furthermore, contrary to demographic trends and developments in social health insurance schemes in other countries, funding health care became even more dependent on its main collection mechanism-payroll tax-and consequently on the employment ratio and wage level. Little effort has been made to diversify the revenue base or to increase the efficiency of revenue collection. Like other countries, Croatia is facing difficulties in adjusting its 'Bismarck' system to its changing demographic and socioeconomic context. Instead of targetting a comprehensive effort at improving revenue collection and limitating unnecessary expenditure and system inefficiencies, simplified approaches to balance the budget have been implemented at a high price to users and with limited effect. As a result, the Croatian health insurance system now offers a lower level of financial protection, while still facing the problem of spending more than can be collected through the current mix of revenue collection mechanisms. The authors suggest that, in order to meet the sustainability requirement of the health financing system, measures affecting both revenue and expenditure should be considered and implemented. On the revenue collection side, the Croatian government must make further efforts to improve collection from the informally employed to broaden the base of contributing members; equally important is the diversification of revenue sources by increasing transfers from general taxation revenues. On the expenditure side, exploring inefficiencies of the delivery system can be delayed no longer, and the introduction of effective cost-control mechanisms and financial discipline would seem to be unavoidable.

[H1; H3] PRISTAŠ, Ivan, BILIĆ, Marinko, PRISTAŠ, Irina, VONČINA, Luka, KRČMAR, Nevenka, POLAŠEK, Ozren, STEVANOVIĆ, Ranko, Health Care Needs, Utilisation and Barriers in Croatia – Regional and Urban-Rural Differences, in: Coll. Antropol. 33 (2009) Suppl. 1, p. 121–130.

Even the most socially aware countries in the world have noticed the gap increase between the poorest and the richest population groups. The purpose of this study was to investigate the presence of inequity and to identify main barriers for equitable health care utilisation by economic status, region and area of living, controlled for health needs in the Croatian adult population. The data from the Croatian Adult Health Survey 2003 were used in this study. The results show that among the respondents with higher health needs, those with an economic status above average had a higher proportion of regular annual general practitioner and medical specialist visits. In contrast, highly frequent visits to physicians were more common in respondents who were below the average economic status. Economically worse-off women, regardless on their health care needs, reported less regular gynaecologist visits than the better-off women. Long waiting times and a large distance from the health care facilities were the most commonly reported barriers in health care utilisation. High expenses were present as the main barrier in dental and inpatient health services utilisation. Suburban and rural settlements were more burdened with long distance from the health care facilities and high expenses for all health services, aggravated by the long waiting times for visits to GP. Respondents from the urban settings reported long waiting times and unkindness of the health personnel as the main barriers. The results of this study clearly show the main barriers in the equitable health care delivery to the Croatian population, from the health care users' perspective.

[H1; H4; H5] OZRETIĆ DOŠEN, Đurđana, ŠKARE, Vatroslav, ŠKARE, Tatjana, Mjerenje kvalitete usluge primarne zdravstvene zaštite SERVQUAL instrumentom, in: Revija za socijalnu politiku 17 (1), p. 27-44, Zagreb 2010.

"Measuring Health Care Service Quality by Using SERVQUAL"

The paper deals with the reflections on the problems involved with the measurement of the quality of health care services. It presents theoretical contributions to a study of specific characteristics of services marketing in health care, including a review of the results of a previous research which measured customer satisfaction with health care services.

Special attention is devoted to a presentation of the most frequently used model of service quality measurement, SERVQUAL, which is also widely used for measuring the service quality within health care. The paper presents the results of a research of the quality of health care services provided by primary health care institutions in the City of Zagreb and the Zagreb County (with a special emphasis on public sector health care institutions) by using the SERVQUAL scale. The research focuses on the extent to which the Croatian customers use the services of the public sector vs. those of private sector primary health care institutions. It attempts to determine the importance paid to individual dimensions of service quality and to find out whether there are any significant gaps between the perceptions by customers and their expectations of the quality of services provided by primary health care institutions. The results revealed a significant gap between the perceptions and expectations by health care service users, while showing that the gap varies according to different dimensions of service quality. The management of public sector primary health care institutions ought to improve their service according to all dimensions of service quality. At the same time, they should pay particular attention to the dimensions where this gap was found to be the largest, i.e. "responsiveness", "assurance" and "reliability". No connection was established

between the size of the measured gap, as far as any individual service quality dimension is concerned, and the significance of that particular dimension for service users as compared to other dimensions. The paper may prompt the management and employees of health care institutions to conduct further measuring of their service quality in the future, so as to identify the elements which must be improved, in order to enhance customer satisfaction.

[H3] GORJANSKI, Dražen, GAJSKI, Lidija, ŠKARIČIĆ, Nataša, SLADOLJEV, Srećko, MARUŠIĆ, Matko, Korupcija u hrvatskom zdravstvu, Osijek, 2010.
"Corruption in Croatian Health Care"

The aim of this book is to clarify fundamental concepts related to corruption in health systems. It clarifies sources of corruption, conditions for it, manners of its achievement and suggest measures of its prevention. No specific cases of corruption are analysed, the book rather contains wider and systematic thoughts of corruption.

[H3; H4] PAP, Jasenka and MIRKOVIĆ, Nevenka, Novine u ostvarivanju prava osiguranih osoba iz obveznog zdravstvenog osiguranja prema Zakonu o izmjenama i dopunama Zakona o obveznom zdravstvenom osiguranju i općim aktima Hrvatskog zavoda za zdravstveno osiguranje, in: Radno pravo 11 (2009), p. 55-60, Zagreb 2010.
"Novelties Regarding Realisation of Rights From Obligatory Health Insurance in Accordance with Applicable Regulations"

The new Act on Amendments to the Act on Obligatory Health Insurance entered into force on 1 August 2009, introducing, among others, modifications as to medical expertise regarding the realisation of certain rights from the obligatory health insurance. The paper analyses these, as well as other important amendments in the field of obligatory health insurance.

[L] Long-term care

[L] ŽGANEC, Nino, Socijalna skrb u Hrvatskoj – smjerovi razvoja i reformi, Revija za socijalnu politiku, god. 15, br. 3, 379-393, Zagreb, 2008.
"Social Welfare in Croatia – Trends of the Development and Reforms"

Following the war conditions, the Republic of Croatia launched significant welfare reforms, among which is the social welfare reform embarked on at the beginning of the 2000s. After completion of the professional background, a political decision was made to restructure the reform and slow it down considerably, which led to a stagnation in the development of the entire social welfare system.

5 List of Important Institutions

Ekonomski institut Zagreb – The Institute of Economics, Zagreb

Contact person: Maja Vehovec
Address: Trg J. F. Kennedyja 7, P.O. box 149, 10000 Zagreb, Croatia,
Webpage: http://www.eizg.hr/

The Institute of Economics, Zagreb, is a public scientific institute that conducts scientific and development research in the field of economics. It is particularly dedicated to conducting empirical research, in order to improve the understanding of Croatia's economy and identify policy measures that could spur its growth and development.
The institute was founded in 1939, and owes its longevity to perseverance in the objectivity and quality of scientific research. Since then, the institute has encouraged freedom of thought and expression. It is independent of any political structure or interest group, and unburdened by ruling ideologies. The impartiality in its scientific work is also derived from mixed financing – approx. 60% of its income is paid from the state budget, while the rest is earned on the market and comes from donations.
Serial Publications:

- *EIZ Working Papers*
- *Economic trends and economic policy*
- *Croatian Economic Survey*
- *Croatian Economic Outlook Quarterly*

Ministarstvo Gospodarstva, Rada i Poduzetništva – Ministry of Economy, Labour and Entrepreneurship

Address: Ulica grada Vukovara 78, 10 000 Zagreb, Croatia
Webpage: http://www.mingorp.hr

The Ministry of Economy, Labour and Entrepreneurship conducts active policy of employment and administrative and other work concerning industry, as well as the involvement in European economic integration; coordination of activities concerning Croatia's membership in the World Trade Organization and participation in multilateral trade negotiations also lie within the framework of this organisation. The ministry conducts administrative and other work concerning: work relations; labour market and employment; relationships with unions and employer associations; labour law status of Croatian citizens employed in foreign countries and work concerning their return and employment in the country; labour law status of foreign nationals employed in the Republic of Croatia; occupational safety; international cooperation in labour and employment sectors and pension and disability insurance system and policy.

Ministarstvo zdravstva i socijalne skrbi Republike Hrvatske – Ministy of Health and Social Care

Address: Ksaver 200a, 10 000 Zagreb, Croatia
Webpage: http://www.mzss.hr/

The Ministry of Health and Social Care carries out administrative and other tasks related to: protecting the population from infectious and non-infectious diseases, ionising and non-ionising radiation; health validity of foods and objects in everyday use; use of health care potentials; construction and investments in health care infrastructure; setting-up of health care institutions and private practices; organisation of state and professional exams for health care personnel and their specialist training; recognition of the primarius title; naming of health care institutions: referral centre, clinic, hospital clinic and hospital clinic centre;

administrative supervision of the functioning of the Croatian Health Insurance Institute, the Croatian Red Cross and chambers; health care inspection of the functioning of health care institutions, health care employees and private practices; drugs registrations, pharmaceutical inspection of manufacturing and distribution of drugs and health products; sanitary inspection of manufacturing, distribution, use and disposition of poisons; manufacturing, distribution and use of narcotics; sanitary inspection of persons and activities, buildings, offices, spaces, facilities and equipment which can have any harmful effects on human health; sanitary inspection of international traffic at the state borders.

Institut za javne financije - The Institute of Public Finance

Contact person: Dr Katarina Ott, Head of the Institute
Address: Smičiklasova 21, 10000 Zagreb, Croatia
Webpage: http://www.ijf.hr

The Institute of Public Finance, founded in 1970, is a public institution dealing with research into primarily economic topics important for economic growth and development, transition to the market economy and meeting the requirements for European integration.
Under the general aegis of public sector economics, topics such as transparency, accountability and participation, the tax system, costs of taxation, progressiveness of taxation, fiscal federalism, the pension system and the welfare system, public debt, the unofficial economy, state aid, foreign direct investment, the financing of science and higher education, and the relations between the executive branch and the legislature in the budgetary process are subjected to ongoing investigation.

Hrvatski zavod za javno zdravstvo – The Croatian National Institute for Public Health

Contact person: Prim. mr. sc. Željko Baklaić, Head of the Institute
Address: Rockefellerova 7, 10000 Zagreb, Croatia
Webpage: http://www.hzjz.hr/index.htm

The Croatian National Institute for Public Health, established in 1923, is a central institution of public health in Croatia. Its task is to monitor and evaluate all factors influencing the health of the Croatian population, including contagious diseases, non-contagious massive chronic and acute illnesses, safe and healthy nutrition, public water supply and waste disposal, as well as information regarding laboratory diagnostics and analytics and various data regarding the organisation and operation of the health care system in its entirety. It publishes various reports and the Croatian Health Service Yearbook.

Pravni fakultet Sveučilišta u Zagrebu, Studijski centar socijalnog rada – Faculty of Law, University of Zagreb, Social Work Study Centre

Contact person: Prof. Dr. sc. Siniša Zrinšćak
Address: Nazorova 51, 10000 Zagreb, Croatia
Webpage: http://www.pravo.hr

The Social Work Study Centre is a place of dissemination of knowledge and research activities in the fields of social policy. The departments organised within the centre include the Social Policy Department, Department of Special Fields of Social Labour, Department of Social Gerontology, Department of Theory and Methodology.
Publishing activities within the centre include the following publications:

- *The Journal of Social Policy – includes a variety of social policy issues, papers on pension, health, family, housing, educational policies, work related issues, unemployment, poverty, social assistance and other social issues and current processes in the society. Along with original papers, the journal also includes translated papers, various documents, statistical data and reviews.*

- *The Yearbook of Social Work Study Centre deals with various subjects, including theoretical and methodological findings and education in the field of social work. Papers from all applied fields of social work and associated fields are also published.*

Pravni fakultet Sveučilišta u Rijeci – Faculty of Law, University of Rijeka

Contact person: Prof. Dr. sc. Nada Bodiroga – Vukobrat
Address: Hahlić 6, 51000 Rijeka, Croatia
Webpage: http://www.pravri.hr/

International conferences in the field of social protection and insurance are organised each year under the auspices of the Faculty of Law Rijeka. The Organisation Committee is chaired by Professor Nada Bodiroga-Vukobrat. The next international conference is scheduled in October 2010, under the title "Regulatory Agencies". In October 2009, the international conference "Open Methods of Coordination" was held, in 2008, the international conference "Social Rights as Fundamental Rights" took place, and in 2007 "Corporate Social Responsibility". In 2006, the topic was cross-border and regional cooperation, while in 2005 the international conference was entitled "Social Security and Competition – European Requirements and National Solutions".
The works of eminent scholars and participants in the conferences are published in the collection of papers which follows each conference.

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en